

'CAN MUMMY COME TOO?'
RHETORIC AND REALITIES OF 'FAMILY-CENTRED CARE' IN
ONE NEW ZEALAND HOSPITAL, 1960-1990.

by

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A thesis submitted to the Victoria University of Wellington

in partial fulfilment of the

requirements for the degree of

Master of Arts (Applied)

in Nursing

Victoria University of Wellington

2001

ABSTRACT:

The development of 'family-centred care' began in the United Kingdom during the 1950s and 1960s in response to 'expert' concern for the child as an 'emotional' being. John Bowlby's maternal deprivation thesis suggested that constant maternal attention in the early years of life would ensure emotionally healthy future members of society. Application of this theory to the hospital children's ward indicated that young children should not be without their mothers for long periods of time. This theory and the subsequent release of the Platt Report in the United Kingdom in 1959 provided the necessary 'scientific' justification allowing mothers greater access to the historically restrictive hospital children's wards.

Influenced by trends in the United Kingdom the tenets of the separation thesis were reflected in New Zealand government policy towards child care and the care of the hospitalised child. However, the wider societal context in which these changes were to be accepted in New Zealand hospital children's wards has not been examined. This study explores the development of 'family-centred care' in New Zealand as part of an international movement advanced by 'experts' in the 1950s concerned with the psychological effects of mother-child separation. It positions the development of 'family-centred care' within the broader context of ideas and beliefs about mothering and children that emerged in New Zealand society between 1960 and 1980 as a response to these new concerns for children's emotional health. It examines New Zealand nursing, medical and related literature between 1960 and 1990 and considers both professional and public response to these concerns. The experiences of some mothers and nurses caring for children in one New Zealand hospital between 1960 and 1990 illustrate the significance of these responses in the context of one hospital children's ward and the subsequent implications for the practice of 'family-centred care'.

This study demonstrates the difference between the professional rhetoric and the parental reality of 'family-centred care' in the context of one hospital children's ward between 1960 and 1990. The practice of 'family-centred care' placed mothers and nurses in contradictory positions within the ward environment. These contradictory positions were historically enduring, although they varied in their enactment.

ACKNOWLEDGEMENTS:

I offer my sincere thanks to the participants who shared, so freely, their experiences of 'family-centred care'. I have attempted to interpret their stories with thoughtfulness and integrity. Their stories afford us the opportunity to examine the past in order that we might make sense of the present.

To my partner Alison and our children Max and India, thank you for your unfailing support, tolerance, and encouragement throughout this study.

To my Mum and Dad, Margaret and Brian Chenery, thank you for letting me 'take-over' your spare room for six months. It not only provided a much needed physical space, but also allowed me the 'head space' in which to think and write.

To my supervisor Dr. Pamela Wood, thank you for your wise counsel and faith in my ability.

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CHAPTER 1:

Researching ‘family-centred care’, 1960-1990

There is not really any such thing as ‘the family’ at all other than as a shorthand term of sociopolitical convenience. The family does not exist: there are only families. And Tolstoy was wrong: even the happy ones are not alike.¹

Emergence of the research idea

The title on my name badge, ‘Children’s Nurse’, belies the extent of my work, as working with children is all about working with families. The importance and centrality of family in children’s lives is undeniable. The concept of ‘family-centred care’ acknowledges this in the context of the hospital children’s ward. In current paediatric nursing practice terms such as ‘parental involvement’ and ‘partnership in care’ are used to describe a method of care delivery that accepts family involvement in the care of children in hospital. Accordingly, the nurse works in partnership with children and families to plan care that is appropriate and acceptable. Recent paediatric nursing literature has suggested that the underlying philosophy of ‘family-centred care’ reflects the tenets of family theories and those relating to child development which consider that family involvement in care improves outcomes for the child.² It would be reasonable to assume that the majority, if not all, New Zealand nurses working in acute care paediatrics would agree with these sentiments as I do and would profess to practise within a ‘family-centred care’ framework. It is pertinent, however, to remember that although the theoretical concept may have evolved in recent years, its application to practice often remains problematic. Sally Nethercott points out that “many nurses claim to practise family-centred care, but open-visiting facilities for parents do not

¹ R. Winder, *The Granta Book of the Family*, Granta Books, London, 1998, p. xvi. (Cited with permission).

² M. Clayton, ‘Health and social policy: influences on family-centred care’, *Paediatric Nursing*, Vol. 12, No. 8, October 2000, p. 31.

constitute true family-centred care – they are prerequisites, but not the essence”.³

Over the past fifty years health professionals working within children’s hospitals and children’s wards have begun to realise the importance of the family in a child’s life. Challenged to accept the applicability of John Bowlby’s maternal deprivation thesis in the hospital setting and the Platt Report’s subsequent recommendations based on this, families are now encouraged to take an active role in the hospital care of their child.⁴ In paediatric practice today it would be unthinkable to plan care that did not involve the child’s family; in fact the ideological soundness of such an approach appears axiomatic. However, I would argue that shaping a culture of ‘family-centred care’ in practice is reliant on more than just theoretical description. As Judith Clare, points out, “as each theory or model appears it becomes historically frozen at that point in time since its underlying epistemology, which is embedded in different models of nursing science, is written into nursing culture”.⁵

As an example, the current practice of ‘family-centred care’ has been informed by a theory of maternal deprivation and the consequences for the child viewed as paramount. Application of this theory to practice has little to do with the promotion of family involvement or participation in the child’s hospital care. Such a situation has contributed, in part, to what I believe are our current practice paradoxes.

One practice paradox, for example, was highlighted in 1998 when I established a ‘reflection on practice’ group within the ward. At the outset I

³ S. Nethercott, ‘A concept for all the family: family-centred care a concept analysis’, *Professional Nurse*, September, 1993, p. 794.

⁴ J. Bowlby, *Maternal Care and Mental Health*, World Health Organisation, Geneva, 1951. Ministry of Health and Central Services Council, *The Welfare of Children in Hospital (Platt Report)*, Her Majesty’s Stationery Office, London, 1959.

⁵ J. Clare, ‘Transforming health care: does nursing theory have anything to offer?’, *Nursing Praxis in New Zealand*, Vol. 6, No. 2, March 1991, p.5.

envisaged that the group would meet to share and reflect on narratives from our practice and from this reflection we might, as a group, illuminate the meaning and experience of 'family-centred care' not only for children and families, but also for ourselves. What eventuated from this group, through mutual sharing and reflection on narratives from our clinical practice, was far from what we individually or collectively imagined.

Narratives and everyday examples from practice suggested that although we worked well as a team and shared similar beliefs and values about nursing, the same could not be said about individual beliefs and attitudes towards families. Paradoxically, we spoke of a blanket acceptance of families as part of the child's hospital care, while in practice we constructed 'the family', who they were, and what they would do, according to either a personal or organisational prescription. To paraphrase Robert Winder, it appeared as though the 'family' in 'family-centred care' did not exist at all, other than as a shorthand term of nursing and organisational convenience. Little attention was paid to the historical, social, political, cultural, gender and personal meanings embedded in the phenomenon of family.

It was not surprising that gender assumptions could be considered implicit in a concept evolving from a maternal deprivation thesis, more surprising was our practice that made these assumptions explicit. When we talked about the 'family' we were more often than not talking about the 'mother'. Involving the 'family' in care was often nothing more than an unspoken expectation that the 'mother' would continue the caring work for her child while in hospital. Our terminology and practice appeared to be poles apart and this begged the question, had the terminology changed to 'family-centred care' for no other reason than sociopolitical convenience or correctness?

This, however, did not appear to be a purely local phenomenon and it was evident from British paediatric nursing literature that enacting 'family-

centred care' continued to be problematic.⁶ There was no common understanding of the concept. In addition, terms such as 'partnership in care', 'involvement in care', 'mutual participation' and 'family-centred care' were used interchangeably.⁷ However, none of them were clearly defined and this contributed to the problems of application in practice.⁸

It was also clear that much of the writing and research related to this topic had originated in the northern hemisphere. It had received considerably less attention from nurses in the southern hemisphere. I was provoked to consider why this might be so and wondered if we might need to examine not only *the* past but *our* past to critically understand the present. I speculated that the paradoxes inherent in our current practice and understanding of 'family-centred care' were historically ingrained and might be better understood when examined within a specific historical and cultural context of time and location. I suggest, therefore, that the way in which paediatric nursing in New Zealand has developed the concept of 'family-centred care' can be understood only in relation to the broader societal context of any given time period.

Focus of the study

The aim of this thesis is threefold. Firstly, it examines the development of 'family-centred care' in New Zealand as part of an international movement advanced by 'experts' in the 1950s concerned with the psychological effects of mother-child separation.⁹ Secondly, it positions the development of 'family-centred care' within the broader context of ideas and beliefs about mothering and children that emerged in New Zealand society

⁶ P. Darbyshire, 'Family-centred care within contemporary British nursing', *British Journal of Nursing*, 4, 1, 1995, p. 32.

⁷ I. Coyne, 'Parent participation: a concept analysis', *Journal of Advanced Nursing*, 23, 1996, p. 733.

⁸ P. Darbyshire, 'Parents, nurses and paediatric nursing: a critical review', *Journal of Advanced Nursing*, 18, 1993, p. 1672.

⁹ See J. Bowlby, *Maternal Care and Mental Health*, and J. Robertson, 'Some responses of young children to the loss of maternal care', *Nursing Times*, April 18, 1953, p. 384.

between 1960 and 1980 as a response to these new concerns for children's emotional health. Thirdly, it examines New Zealand nursing and medical literature and related literature between 1960 and 1990 and considers both professional and public response to these concerns. The experiences of some mothers and nurses caring for children in one New Zealand hospital between 1960 and 1990 illustrate the significance of these responses in the context of one hospital children's ward and the subsequent implications for the practice of 'family-centred care'.

This study provides paediatric nurses with an historical horizon from which to understand the broader contexts that have influenced and may continue to influence the creation and implementation of 'family-centred care' in the hospital setting. It may help guide the current and future practice of paediatric nurses in New Zealand particularly if they are able to scrutinise the development of 'family-centred care' within their own cultural context.

The study period 1960 to 1990 has been chosen for several reasons. Firstly, although calls for freer parental access to children in hospital appeared in the *New Zealand Parent and Child* magazine between 1953 and 1956¹⁰ it did not capture the government's attention until the 1960s. In 1961, the New Zealand Health Department issued a Circular Letter No. Hosp. 1961/45 to all hospital boards seeking to establish the extent to which they were implementing the recommendations of the Platt Report.¹¹ Although only advisory in nature, the issuing of these circular letters to hospital boards meant that hospitals had at least to pay lip service to the new concept of 'family-centred care'. Secondly, the time period of three decades allows sufficient scope to examine the course of changes in conditions for hospitalised children in New Zealand. This is particularly

¹⁰ See, 'Freer parent access to children', *New Zealand Parent and Child*, Autumn 1953, and 'The hospitalisation of young children', *New Zealand Parent and Child*, August 1956.

¹¹ *Circular Letter No. Hosp. 1961/45*, New Zealand Health Department, Wellington.

important, as changes have been described as slow.¹² Thirdly, the end point of 1990 was chosen as in the ensuing years New Zealand began to face major public sector and social policy reform. The health system was not immune to these changes and, as a result, health care delivery priorities for hospitals and health boards were irrevocably changed.

The scope of this historical inquiry is limited to a Pakeha/European understanding of the experiences of caring for a child in one New Zealand hospital between 1960 and 1980 and therefore cannot be generalised as reflective of another cultural group's experience. The main documentary primary source, the *New Zealand Nursing Journal (Kai Tiaki)*, reflected the ideas of the largely Pakeha New Zealand nursing workforce. In regard to the oral histories, although there was no deliberate attempt on my part to omit mothers or nurses of non-European background, the participants in this study are all of European descent. The geographical location of this study and the mode of recruitment would have contributed in part to this.

Primary sources

Nursing and non-nursing literature provided the main primary sources for the study. Primary documentary sources included all available articles, relevant to the development of 'family-centred care' from the *New Zealand Medical Journal* and the *New Zealand Nursing Journal (Kai Tiaki)* between 1960 and 1990. Where relevant, selected 1950s literature from the *New Zealand Nursing Journal (Kai Tiaki)* has been included as context. The *New Zealand Nursing Journal (Kai Tiaki)* has been in existence for ninety-four years. In July 1907 Miss Hester MacLean, Assistant Inspector of Hospitals in the Department of Health, (and therefore the most senior nurse in the country) proposed that a journal be started for New Zealand nurses. Under her editorial guidance and at her own expense, the first quarterly publication of the *New Zealand Nursing Journal (Kai Tiaki)* appeared in January 1908. Although its formal name has changed, the

¹² R. McKinlay, *The Care of Children in New Zealand Hospitals*, National Children's Health Research Council, Auckland, 1981, p.21.

alternate and often more familiar name of *Kai Tiaki* is Maori and means “The Watcher, the Guardian”. The journal remained as a quarterly publication until 1930 when subscriptions were raised and it was then published bi-monthly. In addition to providing a medium for communication among New Zealand nurses, the journal regularly included articles from international nursing journals such as the *British Journal of Nursing* and the *Canadian Nursing Journal*.¹³ Today the journal publication is monthly and it remains the most accessible and widely read nursing publication in New Zealand. As such, it is an important primary source for studies in the history of New Zealand nursing.

New Zealand nursing and health related textbooks published between 1960 and 1990, pertinent to the care of the hospitalised child, have also been examined. Articles from a national magazine and one local newspaper between 1960 and 1990 provided evidence that changes in the hospital care of children were also contested in the public arena and have been included for analysis. Some government policies and commissioned reports between 1960 and 1990 have provided insight into the broader contextual issues that influenced both rhetoric and reaction to the call for increased parental participation in the care of the hospitalised child.

Four oral history interviews were conducted to gather personal accounts from mothers and nurses. A mother whose child was admitted to one New Zealand hospital in the 1960s, and a nurse who was working in the children’s ward at that time, were both interviewed. Similarly, a further two interviews were conducted with a mother whose child was admitted to this New Zealand hospital in the 1980s, and a nurse who was working in the children’s ward at that time. McKinlay has noted that the course of change in conditions for hospitalised children was slow.¹⁴ It was, therefore, expected that acquiring personal accounts from the 1980s, two decades

¹³ H. MacLean, *Nursing in New Zealand*, Tolan Printing Company, Wellington, 1932, p. 72.

¹⁴ R. McKinlay, *The Care of Children in New Zealand Hospitals*, p.21.

following the issuing of government circular letters to hospital boards, would provide a clearer picture of the changes and continuities in the development of 'family-centred care' in one hospital children's ward.

Ethical approval for the oral history interviews was obtained from the Victoria University of Wellington Human Ethics Committee. I outlined my study to the Christchurch Branch of the Incorporated Society 'Friends of Children in Hospital'. This particular branch of the voluntary organisation was established in 1988 to provide both financial and practical support for children, families and staff in the paediatric area. I was aware that there were several nurses in this group who had been working in paediatrics during the time period under study. Owing to the nature and function of this group I anticipated that some of the members might also have had experience of having a child in hospital, or know of parents who might wish to participate in the study. A nurse in attendance indicated to me that she would be interested in being part of the study. I provided her with a nurse participant information sheet (Appendix 1). She also knew a family whose child had been hospitalised in the 1980s and thought they may be interested in being part of the study. She offered to make the initial contact and I provided her with a parent information sheet (Appendix 2). The title 'parent' was used on the information sheet to avoid excluding any fathers that might have identified as being the child's primary caregiver whilst in hospital between 1960 and 1980. Literature from the study period between 1960 and 1990 suggested, however, that child care remained the mother's responsibility and the presence of fathers in the children's ward was seen as the exception.¹⁵ This process was repeated to make contact with a family whose child had been hospitalised in the 1960s and a nurse who had worked in the children's ward at this time. Both potential participants were given the parent and nurse information sheets.

¹⁵ See, J. Ritchie, 'Child rearing patterns: some comparisons', *Research Papers Women's Studies*, University of Waikato, Hamilton, 1979, p. 5, and R. McKinlay, 'Mothers in the children's ward: an examination of the different attitudes expressed by medical and nursing staff about mothers who come to hospital with their sick child', in H.Haines ed., *Women's Studies Association Conference Papers*, Auckland, 1981, p. 216.

All four participants agreed to take part in the study. At this time I phoned each of them personally to discuss the study and to answer any questions that might have arisen from the information sheet. A mutually agreed time was made for the interviews and the participants decided the location of the interview. A letter was sent to each of the participants with details of agreed interview times and dates. I also included with this letter an interview outline sheet (Appendix 3). Participation in the research was voluntary. The nature of the study was explained to all participants prior to commencement of the interviews. Once all participants had had the opportunity to discuss the study with me they were asked to complete the consent form (Appendix 4). All participants had the ability to stop the interview at any time and to withdraw from the study without repercussions at any point until analysis of the interview data commenced. None of the participants in this study are identified by name or by personal information. All tapes and transcripts are in my possession and are stored in a locked cabinet. Transcripts will be destroyed on formal completion of this study. Tapes will be stored for five years in accordance with Victoria University of Wellington protocol. They will then be wiped electronically. All participants were offered a copy of their interview tape, and a letter of thanks was sent to each participant following the interview.

The four interviews provided personal accounts of what it was like for two mothers to have their children in hospital and for two nurses to provide care, in the 1960s and 1980s. These personal accounts illustrate the themes evident in the literature from and about these decades in relation to ‘family-centred care’. The term ‘family-centred care’ is used as a heuristic convenience for the whole time period under consideration regardless of whether or not it was used by people at the time. Differing aspects of this subject are considered in subsequent chapters.

Structure of the thesis

Chapter 2 situates the concept of ‘family-centred care’ in its international context and outlines twentieth century developments in the United Kingdom that were to prove pivotal for change in the care of the

hospitalised child. Professional literature from the United Kingdom, which discussed changes in the care of children in hospital between 1960 and 1970, is used as primary source material.

Chapter 3 considers the hospitalised child in the 1960s. It uses available New Zealand nursing, medical and related literature from the 1960s to examine the care of the hospitalised child, prevailing ideas concerning the child's psychological development and the mother's responsibility for that development. An oral history account from a mother reveals the lived reality of having a child admitted to one New Zealand hospital in the 1960s. Similarly, an account from a nurse who worked in this same hospital in the 1960s illustrates the professional reality of providing care in the children's ward. Both accounts are considered in light of predominant ideas offered in the professional and related literature during this time.

Chapter 4 describes the changes, which occurred during the next two decades. It uses available New Zealand nursing, medical and related literature from the 1970s and 1980s to explore the care of the hospitalised child, attitudes towards children, and the changing role of women during this time period. An oral history account illustrates the changes and the challenges experienced by one mother whose child was admitted to hospital in the 1980s. Again the professional experience of providing care is revealed through the personal account of one nurse who worked in the children's ward of this hospital in the 1980s. Similarly, both accounts are related to the predominant ideas offered in the professional and related literature at this time.

Chapter 5 discusses the findings of this study and considers their implications for current paediatric practice.

CHAPTER 2:

The international context: Development of ‘family-centred care’

The care of the hospitalised child and the development of ‘family-centred care’ cannot be viewed in contextual isolation. I suggest they can be understood only in relation to predominant societal beliefs about children and sick children at any given time period. For instance, although the first foundling hospital had opened in London in 1741, as the name suggested it provided for deserted infants.¹ As regards the sick child, ‘family care’ was generally the only care available. However, by the 1850s, prompted by the appalling social and economic circumstances of many families, British medical ‘experts’ were convinced that families needed help to adequately care for their children when illness struck.² Concern for the sick child had moved from the private to the public domain and ‘care’ would be contested between the ‘expert’ professional and the ‘inexpert’ parent. ‘Family care’ had always attended, albeit in varying degrees of adequacy, to the psychosocial and physical care of the sick child. Hospitalising the sick child also provided care but in isolation from the family.

This chapter does not provide a complete account of all the changes that have historically shaped the hospital care of children. It focuses instead on the significant influence that Dr. John Bowlby’s theory of maternal deprivation had on how the hospitalised child was viewed and the context in which his ideas gained prominence in Britain in the second half of the twentieth century. A review of British nursing, medical and related literature between 1960 and 1970 reveals the professional response to these new ideas concerning the care of the hospitalised child. They provide an international historical context for understanding attitudes towards the hospitalised child and the development of ‘family-centred care’ in New

¹ C. Hardyment, *Dream Babies: Child Care from Locke to Spock*, Jonathan Cape, London, 1983, p. 11.

² I. Miles, ‘The emergence of sick children’s nursing: part one, sick children’s nursing before the turn of the century’, *Nurse Education Today*, 6, 2, 1986, p. 83.

Zealand between 1960 and 1980. The chapter ends by outlining the promotion of John Bowlby's ideas in New Zealand during the 1950s. Following the advice of 'experts' on matters of child care was customary among most Pakeha New Zealand mothers during the 1950s. However, new ideas concerning children's psychological development would signal a departure from the traditional theories of child care that had been advanced by Dr. Frederic Truby King since 1907.

Constructions of childhood in twentieth century Britain

Hendrick suggested that by 1918 "childhood was well on its way to being conceptually modern.....It was increasingly defined in relation to educational, medical, welfarist and psychological jurisdictions, and was clearly separate from adulthood".³ The conceptualisation of childhood was further developed during the inter-war period influenced by psychology, ideas of child development and psychiatry. Psychologist Cyril Burt attended to three groups of children (the delinquent, the developmentally delayed and the gifted) and developed a framework of moral psychology within which psychological conditions took precedence over economic. This in turn placed a particular emphasis and importance on the family, principally the mother, whose role it was to rear emotionally stable children. In Burt's estimation an essential component for sound mental health was a suitably functioning family.⁴

Similarly influential in advancing a psychological construction of childhood was psychologist Susan Isaacs. Her audience was diverse due to the varied forums that gave voice to her opinions on children's intellectual growth. These included: study publications concerned with the social and intellectual development of children; her experimental school in Cambridge; founding the Department of Child Development at the London Institute of Education; as an advocate of nursery education; her 'question

³ H. Hendrick, 'Constructions and reconstructions of British childhood', in, A. James & A. Prout, eds., *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*, Falmer Press, London, 1997, p. 51.

⁴ H. Hendrick, p. 52.

and answer' page in *Nursery World* and *Home and School*; and the information she provided to the Consultative Committee of the Board of Education.⁵ Isaacs believed that children essentially had the same mechanisms of thought as adults did. However, they knew less and their minds were less well developed. In terms of their social development, she considered young children to be "naïve egoists" and aggressiveness the result of an egotistical desire for "possessions, power and attention".⁶ The explanation for this resided in the unconscious, which for the young child was ruled by "basic wishes, fantasies and fears".⁷ The significance of these was impressed upon mothers and she suggested it was sensible to leave the individual child free to determine its own preferred expression.⁸

The third, and in Hendrick's opinion, the most openly institutional influence, was in the establishment of the Child Guidance Clinics in the 1920s and 1930s. Hendrick suggested that "the significance of the clinics was that they took 'nervous', 'maladjusted' and 'delinquent' children and 'treated' them, producing as they did a new perspective of childhood".⁹ More importantly however, was the role of the clinics in issuing social workers, teachers, doctors and psychiatrists, with a new understanding of childhood.¹⁰ Cyril Burt, Susan Isaacs and the Child Guidance Clinics had given 'childhood' significance in three main contexts. These, Hendrick pointed out, were "the mind of the child; the child in the family; and child management. Childhood, it was explained, had an inner world, one that reached into the unconscious and was of great significance for adult maturity".¹¹

⁵ H. Hendrick, p. 52.

⁶ H. Hendrick, p. 52.

⁷ H. Hendrick, p. 52.

⁸ H. Hendrick, p. 52.

⁹ H. Hendrick, p. 53.

¹⁰ H. Hendrick, p. 53.

¹¹ H. Hendrick. p. 53.

Britain post World War II: The influence of Bowlby and Robertson

This new 'child-centred family' would be further defined in the 1950s by the work of Dr. John Bowlby at the Tavistock Clinic in London. His maternal deprivation theory evolved out of a study of the needs of World War II war orphans, children evacuated to rural areas as protection against air raids and children experiencing prolonged hospitalisation. He theorised that there was a naturally occurring biological bond between the mother (or permanent mother figure) and the child in the first three to five years of life. Bowlby postulated that an alteration or damage to this bond, by a lack of opportunity to form an attachment to the mother, separation for a period, or changing mother figure, could be instrumental in later psychological disturbances.

His conclusions were interpreted broadly and implied that the child in its own home was also likely to suffer the harmful consequences of maternal deprivation without full-time maternal attention.¹² Against the background of ideas and beliefs about children and mothering, application of Bowlby's thesis to the hospital setting was inevitable. Young children should not be without their mothers for long periods of time.

In 1952 James Robertson, a research worker with Bowlby at the Tavistock Clinic in London, provided compelling cinematic evidence of the distress young children experienced while in hospital. The film was released as 'A Two Year Old Goes to Hospital' and graphically portrayed a child's emotional unravelment and distress in a hospital children's ward. The fact that hospitals were usually portrayed as restoring rather than destroying one's health pointed to the irony of the situation for the paediatric patient. This did not go unnoticed, however, and served to unite public and professional opinion. Robertson followed this film with another made in 1958 titled 'Going to Hospital with Mother', illustrating that distress could be alleviated by allowing the mother's continued presence.

¹² J. Bowlby, *Maternal Care and Mental Health*, World Health Organisation, Geneva, 1951.

In 1953 he published an article in the *Nursing Times*. Entitled 'Some Responses of Young Children to the Loss of Maternal Care', it called on hospitals to abandon traditional practices that separated the sick child from its mother. Robertson quoted Bowlby and argued that

whether we accept the psychologist's formulation that sound mental health in later life requires childhood experience of a 'warm, intimate, and continuous relationship with the mother or with one substitute-mother', or are content to rely on the intuitive judgements we apply to children in family life, I believe we know this to be true and that traditional practice does offence to this primary need of the young child.¹³

Robertson put forward two solutions that could be included in hospital practice. He suggested that case assignment nursing, and extended visiting with mothers assisting in the care of their children, would go some way in meeting and advancing the primary needs of young children.¹⁴

The Platt Report

Between 1953 and 1959 several other studies were undertaken by both American and British paediatricians and Scottish psychologists investigating the behaviour of young children during and after hospitalisation.¹⁵ Findings from these studies further supported John Bowlby's maternal deprivation thesis and certainly influenced the recommendations of the United Kingdom Committee, which had been appointed in 1956 by the Central Health Services Council of the Ministry of Health. This committee was charged with making recommendations on the welfare of children in hospital. Evidence was gathered from professional groups associated with hospitals: medicine, nursing, social

¹³ J. Robertson, 'Some responses of young children to the loss of maternal care', *Nursing Times*, April 18, 1953, p.384.

¹⁴ J. Robertson, p.384.

¹⁵ See for example H.R. Schaffer & W.M. Callender, 'Psychologic effects of hospitalisation in infancy', *Paediatrics*, 24, (October 1959), pp. 528-539; D.G. Prugh, M. Staub, H.H. Sands, R.M. Kirschbaum & E.A. Leniham, 'A study of the emotional reactions of children and families to hospitalisation and illness', *American Journal of Orthopsychiatry*, Vol. 25, 1953, pp. 70-106.

work and administration. In February 1959 the Minister of Health accepted the committee's report.

Commonly referred to as the Platt Report, it was entitled *The Welfare of Children in Hospital*. The Report's main thrust was to highlight that greater attention must be paid to the hospitalised child's emotional and psychological wellbeing. This was to be accomplished through the Report's main recommendations. Alternatives to in-patient treatment should be available, children should be admitted to children's hospitals or wards, children's nurses should be specifically trained, parents should be able to visit at any reasonable time of the day or night, and organised play and recreational activities should be provided in each ward.¹⁶

Implementation of the Report's recommendations was slow and piecemeal, arguably hampered by government responses that were only advisory in nature. Darbyshire has suggested that "the fate of the Platt Report is perhaps best understood in the light of Florence Nightingale's famous observation that "reports are not necessarily self-executive".¹⁷ Twenty-four years after the publication of the Platt Report a survey conducted by the National Association for the Welfare of Children in Hospital (NAWCH), now called Action for Sick Children, concluded that implementation of the Report's recommendations had only reached a "halfway stage".¹⁸

A survey of the paediatric medical, nursing and related literature from the United Kingdom during the 1960s and 1970s suggested that professionals and parents held differing attitudes about the concept of 'family-centred care' and how this would be enacted within the every day life of a

¹⁶ Ministry of Health and Central Health Services Council, *The Welfare of Children in Hospital (Platt Report)*, Her Majesty's Stationery Office, London, 1959.

¹⁷ P. Darbyshire, 'Parents, nurses and paediatric nursing: a critical review', *Journal of Advanced Nursing*, 18, 1993, p. 1671.

¹⁸ R. Thornes, 'Parental access and family facilities in children's wards in England', *British Medical Journal*, 287, 16 July, 1983, p. 192.

children's ward. Failure to adequately define and agree on the nature of the 'family-centred care' accounted in part for the tardy implementation of the Platt Report's recommendations. I identified three themes from the literature: 'the nature of the family in family-centred care', 'mothers' roles in hospital' and 'nursing attitudes towards family-centred care'. These pointed to the differing interpretations of the concept.

The nature of the family in 'family-centred care'

A focus on individuals and parents within a nuclear family was a predominant theme in most of the literature concerning the hospitalisation of children in the United Kingdom during the 1960s and 1970s. Justification of this rather narrow view of family is perhaps reasonable given the context in which changes to the hospital care of children took place. With the application of Bowlby's maternal deprivation thesis to the hospital setting, it was not surprising that mothers would be given primary consideration over other family members. This theory also highlighted that a child's emotional health and wellbeing warranted the same attention as that given to his or her physical health. However, it is fair to suggest that in the context of the hospital, medical and nursing staff believed that this was just another problem to be solved.

Illustrative of this contention was a 1962 study conducted in the United Kingdom by McCarthy, Lindsay and Morris. Reporting on the experience of admitting one thousand mothers with their children, the authors asserted that "we are concerned here chiefly with children under five years of age, whose dependence on their mother is their peculiar problem as patients."¹⁹ This statement also reflected a medical viewpoint where concerns were directly related to the care of a patient. In this case the child was the patient and the patient's problem was one of dependence on its mother. Admission of the mother was therefore, advised as the solution to this 'peculiar problem'. In this context a broader understanding of family

¹⁹ D. MacCarthy, M. Lindsay & I. Morris, 'Children in hospital with mothers', *Lancet*, March 24, 1962, p. 603.

would have been viewed as irrelevant as it was not directly concerned with the patient's care.

This rather simplistic, problem-orientated approach to 'family-centred care' was highlighted by Dr. S.R. Meadow in his seminal 1969 article entitled 'The Captive Mother'. Advice to the mother from the paediatrician about the considerable advantages that living-in would provide for her child drew this insightful response from Meadow.

For the paediatric consultant, resident mothers are nice to have about. He is no longer just a name on the case notes, he is seen to be doing his job and gets to know mothers he might not otherwise meet. Because he likes resident mothers, and knowing of their great value to the child in hospital, there is a risk of over-persuading mothers to come in; a paediatrician can often persuade the mother to do exactly what he wants. More dangerously, when he is not intending to be over-persuasive, the parents are so anxious to please him that they will agree to his plan when it does not suit them. 'If you ever sat opposite Doctor X when he suggested that it was nice for a child to come into hospital with his mother, you wouldn't dare say you wouldn't.' This means that the paediatrician in giving his views, must be sure to give the alternatives as well, and then leave the parents time to make up their own minds. Many parents do not realise that all-day visiting is routine in most modern children's units, and for some mothers the immense difficulties of making arrangements for the other children outweigh the advantages of being resident.²⁰

These ideas indicate that despite championing this new style of hospital care for children, support was proffered from an entirely professionally-centred view of care. As a result the professional controlled the information and decisions were made on behalf of the family because the professional believed he knew best.

²⁰ S.R. Meadow, 'The captive mother', *Archives of Disease in Childhood*, 44, 1969, p.365.

Bringing about change in traditional hospital practices during this time relied on the acceptance of evidence that mothers should not be separated from their young children for long periods of time. However, many doctors, nurses and hospital administrators remained sceptical about the benefits of having mothers in the children's ward. It is not surprising therefore, that publications at this time continued to promote, often in scientific terms, the exclusivity of the mother over other family members. In the introduction to his 1962 publication *Hospitals and Children: A Parents' Eye-View*, Robertson did just that. He remarked that

this close attachment is readily seen in everyday family life. The two-year old is never far from his mother's skirts. He may venture alone into the garden, or even into the home of a neighbour; but if he gets tired or hurt he wants his mother *and no-one else will do*. Even the most devoted of fathers, knows that in this stage of development the mother is preferred, such is the strength of the primitive biological tendency for a child to attach himself to his mother.²¹

In instances where mothers were admitted with their children it was apparent that professional staff felt that they should determine the suitability of the mother. In a 1968 article, published in the *British Medical Journal*, Brain and MacLay discussed the findings from a controlled study of mothers admitted with their children. They pointed out the problem of the 'difficult' mother who upset the ward routine and caused trouble. Screening and selection of mothers prior to admission was suggested by one of the ward sisters as a way of eliminating potential trouble-makers.²² Such a view highlighted the paradoxical response of professional staff to 'family-centred care' at this time. On the one hand there appeared to be an increasing awareness and acceptance of mothers as part of their child's hospital care. Yet, on the other hand, professional staff constructed 'mothers' according to their own beliefs and values.

²¹ J. Robertson, *Hospitals and Children: A Parents Eye-View*, Victor Gollancz Ltd. London, 1962.

²² D. J. Brain, & I. MacLay, 'Controlled study of mothers and children in hospital', *British Medical Journal*, February, 1968, p. 280.

In a 1970 article for the *Nursing Times*, Elizabeth Anstice highlighted that while resident mothers were becoming a common feature in many children's wards, it was important that nurses were aware that 'family' was more than just the mother and hospitalised child. She pointed out the dilemma faced by mothers who wanted to be resident with their sick child but who had other children at home. Anstice gave nurses practical advice about how best to support mothers as they juggled their responsibilities between hospital and home. She was in favour of maintaining the family unit while the child was hospitalised and asserted that

where brothers and sisters are allowed to visit, this can help a sick child feel less cut off, as well as helping potential future patients overcome any fear of hospital. It is desperately important that a child is cared for, not in isolation, but as part of a family group. If only nurses could think of the child's family, and particularly mother, of course, as allies in their work of making the child well.²³

In a 1978 article David Hall, a research fellow at the Medical Sociology Research Centre, University College Swansea, suggested that an uncritical acceptance of Bowlby's mother-child separation theory had contributed to slowness and inaction on the Platt Report's recommendations. He argued that this purely psychological perspective had turned attention away from other relationships within families and failed to recognise the complexity of subsequent social relationships between families and staff in the children's ward.²⁴

Mothers' roles in hospital

For professional staff at least, it was important that not only should the mother be 'suitable' but she should also be useful if she was going to be present in the ward for extended periods of time. Her usefulness should

²³ E. Anstice, 'Nurse where's my mummy?', *Nursing Times*, 66, 48, November 26, 1970, p.1518.

²⁴ D. Hall, 'Bedside blues: the impact of social research on the hospital treatment of sick children', *Journal of Advanced Nursing*, 3, 1978, p. 29.

extend not only to the care of her own child, but also to the hospital. Meadow's article portrayed this view when he discussed the ways in which resident mothers could be made to feel happier and more useful. Convinced of the acute boredom faced by resident mothers and equating their stay with a prison sentence, he suggested that

they should be told what to do for their own child, and invited to help with other children and share the domestic duties of the ward....nurses must be trained in how to share care with a resident mother and how to use her as an efficient and willing source of labour.²⁵

The words 'share' and 'use' appear diametrically opposed and it is tempting to suggest that a hierarchical relationship existed in assigning and determining the role of the resident mother. Similarly MacCarthy, Lindsay and Morris, while detailing the many things mothers could do for their child, also pointed out that most procedures required the supervision of the trained professional. They noted that "mothers take axillary temperatures, though the nurse reads the thermometer; they give medicines, either under supervision or alone if proved competent (which they often are)".²⁶

These responses to 'family-centred care' cannot, however, be isolated from the context in which they were played out. Even today the hospital remains a microcosm, a world within a world, with hierarchies of knowledge and status, codes of dress and language. Reaction to and an understanding of the mother's role in hospital were mediated through the formalised hospital system. As a formal organisation, the hospital maintains lines of demarcation from the outside world by way of certain procedures and rituals such as the enforcement of visiting hours. The sociological perspectives of the 'Swansea studies' undertaken between February 1965 and January 1966 suggested that the relationship between the hospital and the outside world was altered by the presence of mothers in the ward. In Stacey's view the presence of mothers created a situation

²⁵ S.R. Meadow, p.366.

²⁶ D. MacCarthy, M. Lindsay & I. Morris, p. 603.

where there were no clear lines of demarcation between the hospital and the outside world. She described it in Goffmanesque terms as ‘strangers’ present at all times seeing behind the scenes”.²⁷ She went on to suggest that unless mothers were assigned a distinct role, accepted by them and by professional staff, their presence in the hospital ward was untenable and was likely to be restricted.

The problem of determining the respective roles of mother and nurse when mothers were resident or present in the ward for extended periods of time was also discussed by another of the Swansea studies researchers, Roisin Pill. In contrast to the expectations of the Platt Report, Pill found that nurses did not appreciate mother’s help with various tasks. An exception to this was noted in a particularly busy ward. She also pointed out that mothers had an unrealistic expectation that nurses would be busy all the time. It is fair to suggest that frequent communication between nurses and mothers would have been essential if their respective roles were to be understood and accepted in the ward environment. Pill’s study, albeit inadvertently, highlighted just how infrequently nurses and mothers communicated. She reported on how much time the children interacted with the nurse. Results indicated that when the mother was present interaction with the child ranged from 0 % to 3 % compared to 3 % to 14 % when the mother was absent.²⁸ I would suggest that the apparent unwillingness of nurses to interact with the child when the mother was present, also reflected their reluctance to interact with the mother.

The importance of open and clear communication between nurses and mothers when establishing respective roles was also highlighted by Anstice in 1970. She described mothers’ frustration when they were judged by unarticulated but assumed expectations and noted that

²⁷ M. Stacey, ‘Introduction’, in Stacey, M. (ed.), *Hospitals, Children and their Families*, Routledge & Kegan Paul, London, 1970, p.7.

²⁸ R. Pill, ‘The sociological aspects of the case-study sample’, in Stacey, M. (ed.), *Hospitals, Children and their Families*, Routledge & Kegan Paul, London, 1970, p.125.

often a mother wants to help, but is not told what she can, or can't do, what is expected of her during her stay. 'One day the nurses would tell us off for trying to do something. The next day it was 'haven't you made his bed up yet?''²⁹

It is suggested that the social context of the hospital ward also contributed to the paradoxical response of professional staff to family-centred care. On the one hand mothers were presented with a *fait accompli* by medical staff convinced of the benefits of resident mothers. On the other hand, the experiences of resident mothers were equated, as Meadow suggested, with a prison sentence when their role was not clearly defined. They remained onlookers not accepted as part of the ward.

Nursing attitudes towards 'family-centred care'

It is reasonable to assume that the amount and type of involvement in care which resident mothers experienced was influenced in part by the attitudes of nurses. However, the attitudes of nurses cannot be viewed in isolation. I would suggest that in any given time period, hospital culture and hospital assumptions of mother-child relationships are reflective of the attitudes, values and beliefs of society's dominant culture. This must have accounted for some of the problems that nurses encountered with resident mothers in the 1960s and 1970s.

Writing in 1967, Morgan explained the origins of some of the nursing attitudes that made it difficult to adjust to the continual presence of mothers in the children's ward. She noted that "many senior nurses in children's wards will have trained when visiting was not considered good for the child."³⁰ This ethos of child-care had its roots in the child-rearing ideologies of the early twentieth century when regimented and mechanistic approaches to child-care were considered the norm. In his book *Hospitals and Children: A Parents Eye-View*, Robertson noted that parents perceived

²⁹ E. Anstice, p.1516.

³⁰ B.D. Morgan, 'Mothers in hospital: the nurse's viewpoint', *Lancet*, 2, 425, July 1, 1967, p.38.

nursing staff to be more restrictive and officious than medical staff. The reasons were thought to be related to the differing work responsibility between the doctor and the nurse. He suggested that

the situation in which nurses work can occasion them great anxiety. Doctors prescribe treatment, but for the greater part of the twenty-four hours leave nurses to deputise for them. The nurses are thus placed in positions of great responsibility without them having the doctor's authority or knowledge. To initiate changes therefore, the nurses need the doctor's support and encouragement.³¹

In his article 'The Captive Mother', Meadow also sought to explain the differing attitudes expressed by medical and nursing staff toward resident mothers. From anecdotal evidence he concluded that all nurses in principle supported the idea of resident mothers, although one ward sister suggested that no children's nurse in 1966 would risk saying that she was not in favour.³² This suggested that nurses were caught up in both the rhetoric and reality of the situation but were seldom asked for their perceptions or accounts of what the experience of having mothers resident in the ward actually meant for them. Arguably at this time support for the theory took precedence over how it might be successfully enacted in practice.

Meadow further theorised that resident mothers, with intimate knowledge of their children, usurped nursing staff's authority. Ironically, the move towards greater parental involvement in care was an attempt to counter the historical legacy of paediatrics whereby parents' capability and knowledge of their child was usurped by professionals. Interestingly enough Meadow presumed that resident mothers would usurp only nurses' authority. I suggest that in this historical context, the authority of both the nurse and the resident mother is relevant only in relation to the ultimate authority of the doctor. As Meadow pointed out, "no longer does the consultant say 'and how is he feeding Sister?', instead there is, 'Hello Mrs. Barnes, did

³¹ J. Robertson, p.116.

³² S.R. Meadow, p.366.

Roddy feed normally today?’ In this and other ways the Sister is more subordinate to the mothers than when they live out.’³³ The legitimate authority to deal with this difficulty rested with the doctor and Meadow offered a pragmatic solution.

One way for the consultant to get over this difficulty, and to show that he recognises that care is still shared and Sister’s opinion valuable, is to do a round of the case notes in Sister’s office before going round the ward and talking to the parents; in this way Sister has her say.³⁴

It is fair to suggest that paediatric nurses, at least philosophically, agreed with the Platt Report’s recommendations that favoured unrestricted visiting and live-in facilities for mothers of young children. In practice, however, it would seem that many were less than enthusiastic at the prospect of parents having unfettered access to the ward. In many instances it appeared that the idea of resident mothers was tolerated rather than vigorously encouraged. The controlled experiment in 1968 by Brain and MacLay which allowed a group of mothers to live-in with their child during and after either tonsillectomy and/or adenoidectomy reported that nursing attitudes had remained unchanged at the end of the experiment. The researchers noted that prior to the study the senior nursing sister had verbalised her doubts about the advisability of resident mothers. This tentative response to the idea of having mothers resident in the ward continued throughout the experiment and the authors remarked of the nursing staff that “at the end of the experiment they were unanimous in their opinion that they preferred the children to be admitted on their own”.³⁵ The nursing staff gave the following reasons for their opinions. Nursing tasks were more easily carried out when the parent was not present. They were able to have more personal contact with the child when

³³ S.R. Meadow, p.366.

³⁴ S.R. Meadow, p.366.

³⁵ D.J. Brain & I. MacLay, p.279.

unaccompanied by a parent. And finally, some mothers were labeled as 'difficult' and their behaviour caused upset in the ward.³⁶

Nursing attitudes towards resident mothers also reflected the boundary drawn in the hospital setting between the 'expert' professional and the 'inexpert' parent. This inevitably led to situations where, paradoxically, parents would be both understood and blamed for their apparent lack of expertise. Anstice's article illustrated this paradox. She wrote that the resident mother on the one hand, needed to be understood because "she may, after all, be going through emotional turmoil almost as overwhelming as her child's".³⁷ On the other hand she blamed her for the problems that staff encountered with resident mothers.

It is a fact that, in the enthusiasm for open house for mothers, many of the problems this can present to medical and nursing staff tend to be overlooked. They are, after all, professionals in their field, and having amateurs around is, as one suggested, like having wives on board ship.³⁸

Nursing discourse that described resident mothers as 'thick', 'neurotic', 'lazy' and 'troublemakers' also served to perpetuate the boundary between 'expert' professional and 'inexpert' parent. In Anstice's estimation some mothers were

a support to the child and a help to the nurse. Some, fussy and neurotic, manage to be neither. Some, again, are unbelievably stupid – or perhaps it is too easy to forget that they just do not know the things that any nurse takes for granted.³⁹

³⁶ D.J. Brain & I. MacLay, p.279 .

³⁷ E. Anstice, p.1516.

³⁸ E. Anstice, p.1517.

³⁹ E. Anstice, p.1517.

Summary of the development of ‘family-centred care’ in Britain

Changing the way children were cared for in hospital evolved out of a new image of the child as an emotional being. This was reflected in ‘expert’ concern for the young child’s psychological development and its subsequent impact on later adult life. Bowlby’s maternal deprivation theory suggested that constant maternal attention in the early years of life meant children would develop into mentally and emotionally stable future members of society. Clearly, the liberalisation of the historically restrictive hospital children’s ward was the result of this ‘expert’ concern for the young child’s emotional health. The recommendations of the Platt Report considered extended parental presence to be essential as it provided the young child with a sense of emotional stability whilst in hospital. Bowlby’s theory provided the ‘scientific’ justification that would allow mothers greater access to the hospital children’s wards and in some instances enable them to live-in with their child. However, the reviewed nursing, medical and related literature has pointed out that in the context of the hospital children’s ward application of Bowlby’s theory was further defined and carefully controlled by medical and nursing ‘experts’ who worked within the formalised hospital system. The remainder of this chapter considers the translation of Bowlby’s and Robertson’s ideas to the New Zealand setting.

The child as an emotional being: The New-Zealand connection

Post-war New Zealand society was exposed to these new international views that shifted attention from the child’s physical to its emotional health by a local ‘expert’, psychiatrist Maurice Beaven-Brown. Having returned to New Zealand in the 1940s after eighteen years working at the Tavistock Clinic in London, he had expressed dismay at the lack of attention New Zealand child care ‘experts’ paid to the child’s mental health. Beaven-Brown’s attitude towards psychological theory and practice was essentially Freudian, as was Bowlby’s. In the introduction to his book *The Sources of Love and Fear*, published in 1950, he wrote that

the evidence is now overwhelming that a large proportion of this [mental] illness has its origin in the earliest years of life and is a consequence of faulty nurture; and it is at this period especially that the principles of mental health must be applied. It is a matter of good parenthood, and especially good motherhood.⁴⁰

Beaven-Brown promoted demand breast feeding and stressed that babies in the first year of life should never be left to cry. He was psychiatric consultant to the Wellington Branch of Parents Centre, an organisation formed in 1952. His views and those of Bowlby shaped the ideology of the Parents Centre. The importance of the mother-child relationship was emphasised in the majority of their literature.⁴¹

These ideas represented a departure from the child-rearing ideology of Dr. (later Sir) Frederic Truby King, prevalent since 1907, that promoted rigid 'by the clock' feeding and sleeping schedules for babies. Playing and cuddling were regarded as unnecessary emotional interactions that spoilt the child.⁴² This approach to childcare had shaped the way most Pakeha New Zealand children were raised since 1907 when King established The Royal New Zealand Society for the Health of Women and Children. Better known as the Plunket Society, in honour of Lady Plunket who was wife of the then Governor- General, its aim was to reduce the infant mortality rate by improving standards of maternal care. Initially the physical aspects of infant care were addressed. The importance of breast-feeding was stressed and mothers were warned of the dangers of substituting cow's milk. Ensuring that mothers heeded this and other advice would be the responsibility of the Plunket Nurse and by 1947 85% of all Pakeha babies were under their watchful eye.⁴³ These 'experts' regularly assessed the

⁴⁰ M. Beaven-Brown, *The Sources of Love and Fear*, A.H. & A.W. Reed, Wellington, 1950, p. xi.

⁴¹ S. Kedgley, *Mum's the Word*, Random House New Zealand Ltd., 1996, p. 168.

⁴² H. May, *The Discovery of Early Childhood*, Auckland University Press with Bridget Williams Books, Auckland, 1997, p. 145.

⁴³ H. May, p. 140.

mother's abilities and achievements against her infant's charted weight. The Plunket Society's goal was to deliver preventative health care advice. However, under the tutelage of King, delivery would reflect his beliefs about the role of women and the character of children. In fact in the 1960s the first recorded aim of the Society was still to "inculcate a lofty view of the responsibilities of maternity and the duty of every mother to fit herself for the perfect fulfilment of the natural calls of motherhood".⁴⁴

Eric Olssen and Andree Levesque have suggested that the rise of the Plunket Society was part of a broader change that took place in New Zealand society between 1880 and 1920. They referred to it as the "cult of domesticity" which raised the role of housewife and mother to a science for which specific training was required.⁴⁵ In effect King's ideology merely reinforced existing beliefs and he was able to draw on the authority of science to legitimise them. Although King's ideology reflected the existing cult of motherhood, Olssen has pointed out that it was subtly changed so that mothers were now "subject to the control of outside experts".⁴⁶ Throughout the intervening years the Plunket Society continued to vociferously promote the necessity for 'expert' guidance on all matters of child care.

As the reviewed British literature has suggested, new ideas concerning the psychological development of the child and the mother's responsibility for that development also had profound implications for the care of the hospitalised child. These ideas indicated that the mother's presence was beneficial to her child and she should be encouraged to stay in hospital with her child. I would suggest, however, that in the context of New Zealand society the legacy of the Plunket Society continued to influence

⁴⁴ *The Royal New Zealand Society for the Health of Women and Children (Plunket Society) Annual Report of Council 1960-61*, Stone Son & Co., Dunedin, 1961.

⁴⁵ E. Olssen, & A. Levesque, 'Towards a history of the European family in New Zealand', in P.G. Koopman-Boyden, ed., *Families in New Zealand Society*, Methuen, Wellington, 1978, p. 6.

⁴⁶ E. Olssen, 'Truby King and the Plunket Society: an analysis of a prescriptive ideology', *New Zealand Journal of History*, Vol. 15, No. 1, April 1981, p. 21.

the response of both parents and professionals to these new ideas. New Zealand's adult population in the 1950s and 1960s, most born between 1910 and 1930, had absorbed King's teachings.⁴⁷ He had deemed that raising a healthy infant was a task unlikely to be achieved safely without ongoing supervision by a trained professional. It was already a culturally accepted practice, at least among Pakeha families, to hand over the care of their sick child if hospitalisation was required. With 'expert' help needed for both a healthy and a sick child, what possible role could a mother, as an untrained amateur, have in the care of her sick child in hospital?

There appeared to be minimal response in New Zealand's professional nursing literature during the 1950s to the prospect of mothers being resident in the children's ward. In a 1953 article for the *New Zealand Nursing Journal*, Miss Flora Cameron, Director, Division of Nursing in the New Zealand Health Department, discussed the acceptable standards of paediatric nursing service. Cameron noted that visiting in the children's ward had undergone change. She explained that it was now thought that daily visiting should be instituted for children between the ages of three and six. However, although daily visiting was to be encouraged, she remarked that "it will probably be one of the modern trends, which will not be readily accepted".⁴⁸

Cameron also pointed out that specialised training in infant welfare was provided by the Dominion Training School founded by the late Sir Truby King. All nurses in charge of paediatric wards received this training and a government bursary system operated which enabled them to do so. I would speculate that this training would have also reflected the broader Plunket ideology concerning the role of the mother in relation to the 'expert'. The

⁴⁷ E. Olssen & A. Levesque, p. 18.

⁴⁷ F.J. Cameron, 'Acceptable standards of paediatric nursing service', *New Zealand Nursing Journal*, October 15, 1953, p. 149.

⁴⁸ 'Supplementary instructions for the training of nurses', *Curriculum issued by the Nurses and Midwives Board, Pursuant to Regulation 7 (3) of the Nurses Registration Regulations 1958*.

mother's was a passive role and the professional 'experts' who came to her home taught her methods of child care. Given this local background it is hard to envisage that New Zealand nurses would ever have conceived of a situation whereby mothers would play an extensive role in the hospital care of their child. However, by 1958 there was evidence to suggest that knowledge of children's emotional health was as important as their physical health. The Plunket manual *Modern Mothercraft* was still a suggested text for paediatric nursing in 1958, however, it appeared alongside others such as Bowlby's *Child Care and the Growth of Love* and *The Nursery Years* by Susan Isaacs.⁴⁹ With these texts offering differing views of a child's 'needs', and appropriate responses to them, it is not surprising that nurses in practice demonstrated differing, contradictory and confusing notions of the mother's role in hospital.

Chapter 3 examines the effect that new ideas concerning the child's psychological development had in the broader context of New Zealand society and in the hospital children's ward.

CHAPTER 3:

Can mummy come too?

Despite its geographical isolation New Zealand was still influenced by changes in the international arena of which it was a part. Those changes that heralded a radical alteration in the organisation of hospital care for children were no exception. However, the local context in which these changes were to be accepted has not been examined. This chapter describes the emerging paradigms of childhood and motherhood in post-war New Zealand society. Integral to the change in attitudes and beliefs about children and mothering was the prominence of psychological theories of child development. A new range of child care ‘experts’, versed in the psychological needs of children, became favoured over the authoritarian and didactic style of the Plunket Society ‘expert’ familiar to most Pakeha New Zealand families. Bowlby’s maternal deprivation theory was particularly influential and was utilised to advance both ‘expert’ and government agendas that were opposed to mothers working outside the home. As in Britain, its tenets were applied to the New Zealand hospital environment and the ensuing changes attested to the new concern for the child’s psychological wellbeing.

This chapter examines New Zealand nursing, medical and related literature from the 1960s, concerned with the needs of children sick and healthy in relation to these themes. The extent to which professional rhetoric subsequently influenced the reality of practice in one New Zealand hospital during the 1960s is illustrated by the oral history account of one mother whose child was hospitalised during this time and one nurse who worked in the children’s ward.

New Zealand’s post-war paradigms of motherhood and childhood

Calls for change in the care of hospitalised children had their genesis in new ideas concerning the nature of children, which began to emerge internationally in the 1940s and 1950s. Post-war New Zealand society was not immune to the influence of these new views, and given the

circumstances, these appeared cogent. Dugald McDonald has suggested that there were two prominent themes running through post-war New Zealand society, pre-school education and juvenile delinquency. Given the innovations in response to these issues, he has characterised the period of 1945 to 1969 as a time when the New Zealand child was viewed as a “psychological being”.¹ The convergence of several contextual factors also fuelled the desire to find new approaches that would ensure a happier and healthier future world. In particular, these were rapid economic, social and demographic changes.

The effects of rapid economic and social change after the ravages of war were exhibited in peacetime New Zealand society.² Both Pakeha and Maori populations grew rapidly, with the Pakeha population experiencing a ‘baby boom’. The late 1940s saw the European birth rate rise to over 26 per 1,000 compared with just over 16 per 1,000 in 1935-36.³ Internal migration increased and for some families this meant support from the extended family was lost. The urbanisation of the Maori people had begun during the Second World War. The process continued up until the late 1960s when, as Michael King noted, “Maori had become a predominantly urban people”.⁴ The rapid population growth saw the creation of modern new suburbs, but without the accompanying facilities such as shops and easy access to public transport. The war had also created new opportunities for women and the phenomenon of the ‘working mother’ was an issue that questioned pre-war values.⁵ In fact the number of married women in full-time employment increased markedly in the post-war period

¹ D. McDonald, ‘Children and young persons in New Zealand society’, in Koopman-Boyden, P.G. (ed.), *Families in New Zealand Society*, Methuen, Wellington, 1978, p. 49.

² D. McDonald, ‘Children and young persons in New Zealand society’, p. 49.

³ G. Dunstall, ‘The social pattern’, in Rice, G.W. (ed.), *The Oxford History of New Zealand*, Oxford University Press, Auckland, 2nd edition 1992, p. 454.

⁴ M. King, ‘Between two worlds’, in Rice, G.W. (ed.), *The Oxford History of New Zealand*, Oxford University Press, Auckland, 2nd edition 1992, p. 289.

⁵ D. McDonald, p. 49.

surpassing the rate of growth in the male workforce.⁶ Between 1926 and 1961 the female labour force increased by 145%. In comparison the male labour force only increased by approximately 75% in the same period. The proportion of married women in the workforce during this period had also increased from 3.5% to 16%.⁷ This, as Melanie Nolan pointed out, “was starting to attract attention”.⁸ The 1954 Report of the Special Committee on Moral Delinquency in Children and Adolescents (the ‘Mazengarb Report’) linked the escalating problem of juvenile delinquency to mothers who worked outside the home. The Report noted that “nearly one-third of the delinquent children whose cases were considered by the Committee belonged to homes where the mother worked for wages”.⁹ It was therefore not surprising, as McDonald has suggested, that “psychological adjustment should emerge as the method to assist socialisation and forestall the alarming incidence of juvenile delinquency”.¹⁰

This dominant attitude towards children in New Zealand society was reflected in the rapid growth of child-centred services. The Psychological Service of the Department of Education was established in 1946. From 1950 child health clinics were set up providing for the needs of maladjusted children, courses in clinical psychology began in 1965 and child psychiatry in 1966.¹¹ Organisations emerged such as the Parents Centre in 1952 and the New Zealand Federation of Home and Schools Associations. The Federation’s publication, *New Zealand Parent and Child*, supported the new child-care ideologies that accepted that love, attention and encouragement by the mother were the key to successful child-rearing. The ‘rod’, which until now had taught the child self-

⁶ P.G. Koopman-Boyden & C.D. Scott, *The Family and Government Policy in New Zealand*, George Allen & Unwin, Sydney, (1984), p. 135.

⁷ M. Nolan, p. 248.

⁸ M. Nolan, *Breadwinning*, Canterbury University Press, Christchurch, 2000, p. 248.

⁹ *Appendices to the Journals of the House of Representatives*, 1954, Vol. 1V, p. 39.

¹⁰ D. McDonald, P. 49.

¹¹ D. McDonald, p. 50.

discipline and self-control, was to be replaced by new psychological methods of child management.¹² Underpinning these developments was an assumption that adult adjustment could be explained in psychological terms and bore a direct relation to the character of the childhood experience.¹³

It is hardly surprising that this new view of the child would have its most profound affect on mothers. Robin McKinlay has suggested that ‘the child as psychological being’ paradigm has in turn defined the experience of mothering during this period. She has called this paradigm ‘motherhood as service’ because mothers were exemplified “as servicing the needs of their children”.¹⁴ The emergence of the ‘motherhood as service’ paradigm in the 1950s and 1960s intimated that mothers would adjust their lives according to the needs of their children. In this style of mothering conformity was still assumed but now the individual needs of the child took precedence over general rules and standards. The scientific ‘laws’ of nature that governed the earlier paradigm and prescribed the correct response to the child’s needs were now embedded in the mother’s ‘instinct’ and there was an assumption that she would acquire a certain level of expertise about her own child.¹⁵

This represented a departure from an earlier paradigm in which motherhood was viewed as a social identity. Prevalent in early twentieth century New Zealand, this paradigm assumed that women and children would conform to particular rules and standards of ‘good mothering’ and ‘good behaviour’. McKinlay points out that this paradigm “is one which reduces motherhood to this kind of social identity, and which gives priority

¹² H. May, *Minding Children, Managing Men: Conflict and Compromise in the Lives of Post-war Pakeha Women*, Bridget Williams Books, Wellington, 1992, p. 143.

¹³ D. McDonald, ‘Children and young persons in New Zealand society’, p. 49.

¹⁴ R. McKinlay, ‘Motherhood and self-definition in New Zealand’, Ph.D. thesis, Victoria University of Wellington, 1983, p. 137.

¹⁵ R. McKinlay, p. 139.

and value to the rights and duties associated with the categories ‘mother’ and ‘child’ over the possibility of individual variation”.¹⁶

In the child’s best interests

In 1961, prompted by the publication of the Platt Report in 1959, the New Zealand Department of Health issued a questionnaire, Circular Letter No. Hosp. 1961/45, to New Zealand hospital boards. This questionnaire endeavoured to establish the extent to which hospitals complied with the recommendations of the Platt Report.¹⁷ Requests for information were categorised utilising some of the Platt Report’s main recommendations. These included hospital admission policies versus home care, admission of children to adult wards, visiting hours, the extent to which mothers were involved in the care of their sick children, educational facilities, the employment of a paediatrician on the hospital board staff and anaesthetic procedures for children. The responses to this survey were analysed by the Child Health Council. New Zealand, it appeared, was far from meeting the requirements stipulated by the Platt Report. This was evidenced by findings that children in the larger hospitals were still being admitted to adult wards and visiting hours for children were restricted in nearly all hospitals. However, there did appear to be a move towards unrestricted visiting for parents. In some instances the presence of the mother at meal times and bedtime was encouraged. Living-in with a sick child was noted by only one hospital but with the codicil “in certain circumstances”.¹⁸

There was, however, some evidence to suggest that the tenets of the separation thesis were influencing the decisions of some hospital boards. In 1961 there were plans for a new children’s unit in Christchurch. Reporting on this an article in *The Press* noted that “a special point was that beds would be available for the mothers of sick babies. Emotional

¹⁶ R. McKinlay, p. 117.

¹⁷ *Circular Letter No. Hosp. 1961/45*, New Zealand Department of Health, Wellington, 1961.

¹⁸ R. McKinlay, *The Care of Children in New Zealand Hospitals*, p. 21.

disturbances arising from the separation of a child from its mother could sometimes be severe”.¹⁹

Given the paradigms of motherhood and childhood prevalent at this time, it is not surprising that questions concerning the involvement of parents in the care of the hospitalised child focused exclusively on the mother. Indeed it was mothers who were deemed ultimately responsible for the emotional health of their children. Geraldine McDonald noted the wholehearted acceptance of Bowlby’s ideas by New Zealand government departments and other agencies responsible for the health of young children and pointed out that “the nett result was that whether or not women knew of Bowlby’s ideas they were likely to be affected by them”.²⁰

The influence of psychological theories in New Zealand at this time was highlighted by a review of child health services in 1963. Although improving the health and welfare of children remained the primary aim, it was deemed that linking maternal and child health would make the family the focal point. “The scope widened to include working with the whole family from the time a baby was taken home from the maternity hospital, through pre-school and school years. Thought was given to future adjustment into adult life.”²¹

Professional rhetoric

This emphasis on the family and the influence of ‘experts’ was picked up in New Zealand nursing and related literature. World Mental Health Year was marked in 1960. The March 1960 editorial in the *New Zealand Nursing Journal* urged nurses to think about their responsibilities in promoting mental health, whatever their chosen area of professional activity.

¹⁹ ‘Hospital board’s plans for children’s unit’, *The Press*, March 2, 1961, p.14.

²⁰ G. McDonald, ‘Maternal deprivation fact or fallacy’, *Set*, No. 1, Item 3, 1977.

²¹ *Appendices to the Journals of the House of Representatives*, 1969, Vol. 4.

It pointed to the multiplicity of theories concerning the origins of mental ill health, concluding that most were thought to arise from emotional insecurity in infancy and childhood. Accordingly it was suggested that “no reasonable person would dispute the theories of such eminent writers as Dr. John Bowlby”.²² But despite the pervasive influence of Bowlby’s ideas a cautionary note was offered, suggesting that it was possible for such theories to be over emphasised. However, this situation was deemed to be a result of the theories of ‘expert’s’ being popularised and “embraced by lay persons who have not the background of knowledge to evaluate the reasoning stated or implied”.²³

It was considered that nurses, by virtue of their nursing education, had the skills to appraise available information irrespective of whether the source was professional or non-professional. It was therefore, suggested that in the current climate, when “so many pseudo-scientific theories regarding the origins of mental ill-health are under discussion”,²⁴ that it behoved the nurse to scrutinise these theories and when the need arose to oppose such with logic and objectivity. Indeed, composed and balanced judgements were suggested as evidence of sound mental health. In contrast, “fanatical devotion” to any theory was perceived as being at odds with the “accepted criteria of mental health”.²⁵

A reprint of a *New Zealand Listener* article also appeared in the March 1960 journal. The writer, a sociologist Eileen Saunders, raised the question ‘Are There Too Many Experts?’ and lamented the change in society’s views on parenthood. She pointed out that child raising was not a new activity for parents. While some parents would always fair better than others in raising their children, parenthood nonetheless still remained a

²² ‘A thought for World Mental Health Year’, *New Zealand Nursing Journal*, March 1960, p. 4.

²³ ‘A thought for World Mental Health Year’, p. 4.

²⁴ p.4.

²⁵ p. 4.

desirable role and one that could be undertaken without undue worry or anxiety.²⁶

Comparing this attitude toward parenthood with the prevailing trend, Saunders commented wryly that “now, however, we live in a blaze of enlightenment. We have a new ‘they’; the ‘Establishment’ of experts, who are helping us in this field”.²⁷ This, she suggested, was resulting in a growing sense of confusion among parents as they were bombarded with theories on how to bring up their children. Although she makes no mention of any one particular theory it is tempting to speculate that Bowlby’s maternal deprivation thesis might have been uppermost in her mind, given the following excerpt:

The advice givers in this field often forget or ignore that they are not propounding proven scientific fact but only conclusions based on observation, which is a very different thing.... But to state that, “a child will develop in such a way if such a course of action is taken” is not to state a proved fact. It is simply to give an opinion based on the viewer’s observation and interpretation of the facts. He will very probably have observed a great many cases, but he cannot control his material as you can in the physical sciences, he cannot reproduce his experiment exactly because all people are different, nor, since we are complicated beings can he prevent outside factors having any influence. The conclusions he reaches may very well be right, but since so many subtle factors enter into human development he cannot satisfactorily be proved or disproved. The balance of evidence may perhaps be on his side but it still remains a theory and not a fact in the scientific sense. There would seem to be little justification for speaking and behaving as though such theories were immutable laws, which we ignore at our peril.²⁸

²⁶ E. Saunders, ‘Are there too many experts?’, *New Zealand Nursing Journal*, March 1960, p. 5.

²⁷ E. Saunders, p. 5.

²⁸ E. Saunders, p.5.

Ironically, the article following it was written by one of the ‘experts’, Dr. Neil Begg, Medical Director to the Plunket Society since 1957. In it he surveyed the emotional health and development of the pre-school child. He described the broad patterns of emotional development in the young child and noted that every child had their own unique way of growing within these patterns. Experience was the child’s guide and those experiences were closely related to the reactions and responses of the mother, the influence of the environment and family life. Begg believed that parents had an important role in assisting their children to form sound emotional habits. Yet paradoxically he suggested that it was potentially dangerous for parents to have “a too high-powered psychological approach”.²⁹ He went on to explain that “the cold scientific detachment which permits this objective view has little to commend it in a parent”.³⁰ These comments quite clearly drew a distinction between the knowledge of the ‘expert’ and the knowledge of the ‘inexpert’ parent. This stance is of interest given the shifting paradigm of motherhood at this time, which McKinlay has suggested began to pose questions concerning the boundaries between mothers and experts.³¹

World Mental Health Year continued to provide the impetus for further articles in the *New Zealand Nursing Journal* concerned with the emotional health of children. In one article, originally presented as a conference paper, nurse Wendy McIvor examined the aspects of mental health in children. The opening paragraph reminded readers of the seal for World Mental Health Year 1960: the man, the woman and the child. This seal represented the home and togetherness, on which the mental health of children rested.

²⁹ N. Begg, ‘The emotional health of the pre-school child’, *New Zealand Nursing Journal*, March 1960, p. 9.

³⁰ N. Begg, p. 9.

³¹ R. McKinlay, ‘Motherhood and self-definition in New Zealand’, p. 140.

McIvor's comments, in contrast to Begg's, reflected the new paradigm of motherhood. Implicit in this new paradigm was the expectation that motherhood would be a happy experience. Mothers were considered the key to raising well-adjusted emotionally secure children. McIvor agreed, claiming that "no doubt you are all aware of the necessity of a sound mother and baby relationship for the development of good mental health in the child. This begins before the birth of the babe, with the joyous anticipation of the mother to the child".³² Motherhood's elevation in status was, however, a double-edged sword, as McIvor's comments indicate.

If the mother does not want her unborn child for various reasons the child may be born with a feeling of insecurity. Mother gives the child his first feelings of love, warmth and security...his future adult outlet and relationships will be affected to a larger extent by the characteristics developed up to and during this time. Subsequent experience, relationships and opportunities will only change these characteristics to a limited extent.³³

If mothers were responsible for raising emotionally secure children, then they must also be culpable for the emotionally insecure children, the maladjusted adults of the future.

The *New Zealand Nursing Journal* was not the only nursing publication in New Zealand at that time concerning itself with the growing interest in the psychological aspects of child health. Since 1941 the Division of Nursing in the Department of Health had published *The Nursing Gazette* and from 1957 included the *Industrial Nurses Bulletin*. This publication served as a source of information for district nurses, public health nurses and occupational health nurses. An extract from the *Family Doctor*, April 1961, by Dr. Alan Moncrieff, Professor of Child Health, University of London, was reprinted in the November 1961 issue of *The Nursing Gazette*.

³² W. McIvor, 'Aspects of mental health in children', *New Zealand Nursing Journal*, August, 1960, p. 29.

³³ W. McIvor, 'Aspects of mental health in children', p. 29.

Moncrieff advised readers that scientific progress in the treatment and control of physical disorders in infancy and childhood in the previous ten years had meant that medical attention could now concentrate on the emotional needs of children.³⁴ He remarked on the increasing interest in the psychological disorders of infancy, noting “especially the possible damage done to a child’s emotional development by any sort of prolonged separation from his mother”.³⁵ He went on to outline the effect of such theories on the children’s hospitals and children’s departments. By contextualising the situation, Moncrieff’s comments could be interpreted as reference to psychiatry’s theoretical rather than empirical studies on which practice innovations were made. He pointed out that “...gradually experiments in visiting began, stimulated to some extent by child psychiatrists although, it must be remarked, they seldom have the direct responsibility for the lives and welfare of a ward of sick children”.³⁶

Moncreiff noted that due to government endorsement visiting was now to be encouraged. His comments, however, suggested that he remained unconvinced of the benefits and practicalities of regular visiting. He suggested that some wards were unable to cope with visitors. Parental anxiety and distress were easily communicated to the young child. It was therefore, presumed that increased contact with a stressed or anxious parent heightened the child’s feelings of insecurity and abandonment. As to living-in with a child, Moncreiff cited family duties and the physical constraints posed by current hospital buildings as reasons why in his estimation it was “only necessary in relatively few cases”.³⁷

³⁴ A. Moncrieff, ‘Ten years of child health’, *The Nursing Gazette*, Vol. 19, No. 5, November, 1961, p. 55.

³⁵ A. Moncrieff, ‘Ten years of child health’, p. 55.

³⁶ A. Moncrieff, p. 55.

³⁷ A. Moncrieff, p. 55.

The 'family' and 'family life' and their importance for healthy child development, were prominent themes in some of the articles published in the *New Zealand Nursing Journal* and the *Nursing Gazette* during 1962 and 1963. Mr. D. McAlpine, a lecturer in education at the Waikato branch of Auckland University, offered his opinion concerning child growth in a 1962 article for the *New Zealand Nursing Journal*. He noted the rapidly changing patterns of family life in New Zealand in both parent-child and husband-wife relationships. He suggested that the husband-wife relationship had evolved from a patriarchal to a more democratic one where both parties shared responsibilities equally. However, this suggestion became a moot point when he stated that "some career-minded mothers work without prejudicing the development of their children. In other cases, however, such employment must be weighed against other values of child development".³⁸ It remains a debatable point as to whether such a statement is a veiled reference to Bowlby's maternal deprivation thesis. Nevertheless these sentiments would appear to be consistent with the wider societal view at this time which held that women should define themselves in terms of their children.³⁹

A 1963 editorial in *The Nursing Gazette* also pondered on the state of the 'family' in New Zealand and pointed out that "we are beset with difficulties arising from the advent of the working mother".⁴⁰ In a more conciliatory tone the author followed this declaration by suggesting that criticising working mothers was both futile and uninspired. Nurses instead should look ahead and be prepared to deal with the changes in family patterns and ensuing difficulties created by this increase in the number of working mothers.⁴¹

³⁸ D. McAlpine, 'Modern view of child growth', *New Zealand Nursing Journal*, August 1962, p. 16.

³⁹ See R. McKinlay 'Motherhood and self-definition in New Zealand', and H. May, *Minding Children Managing Men*, Bridget Williams Books, Wellington, 1992.

⁴⁰ 'Today's family', *The Nursing Gazette*, Vol. 21, No. 5, November 1963, p. 1.

⁴¹ 'Today's family', p. 1.

Other forums also addressed matters concerning child health. In 1963 the Operational Research Unit of the New Zealand Health Department was charged with making recommendations to the Department of Health and the North Canterbury Hospital Board on the provision and organisation of hospital accommodation on the basis of survey data. The subsequent report was entitled *Patient-Nurse Dependency Paediatrics*. The report was one of a series of surveys of patient-nurse dependency made in three hospitals managed by the North Canterbury Hospital Board. The report's introductory comments noted that the term 'paediatric' referred to children not yet thirteen years old. A separate report was devoted to paediatrics because, in the words of the report, "hospital patients of this age range have needs which are characterised by age as well as by the clinical speciality".⁴²

There were two wards designated as children's wards at Christchurch, The Princess Margaret and Burwood Hospitals at that time. The survey covered eighty-eight days for Christchurch Hospital, eighty-six for The Princess Margaret Hospital and ninety-one days for Burwood Hospital. In a breakdown of children inpatient load, the report found that of the 94.3% load at Christchurch Hospital, 19.7% of children were admitted to adult wards. This finding is of interest given the report's earlier statement concerning the differing needs of hospitalised children. It was noted, however, that with few exceptions, children in the age range 0-2 years were admitted to Ward 9A, the thirty-bed babies' ward. Ironically, facilitating consultation with the paediatrician was cited as the most important reason for this. This is surprising when considered in the context of a heightened concern for the infant's emotional health and development.

Children aged two to twelve years did not fair so well. No criteria were given for the decisions to admit these children to the children's ward,

⁴² New Zealand Department of Health, *Patient-Nurse Dependency Paediatrics*, New Zealand Department of Health, Wellington, 1963, p. 5.

ward 9B, or to some other ward. Paediatric dependency was concerned with 'expert' care which in this instance meant whether or not a child required hospital inpatient care. The report stated dependency was concerned with "the number of consecutive days immediately before discharge on which a child did not receive any of the recorded items of special nursing care under the headings mental state, dressings, drainage, suction, orthopaedic treatment, special drugs, IV fluid, oxygen, major observation and special nurse".⁴³ The report noted that analysis of dependency data by category, useful in adult patients, was ambiguous when applied to paediatric patients. It went on to explain the reasons for this concluding that young children, whether they were in hospital or not, were dependent on others to help them with their bodily functions.

As a result a distinction had been drawn between 'expert' care, which nurses carried out, and 'inexpert' care, considered a normal part of the child's everyday life. Arguably this 'inexpert' care, consisting of tasks such as feeding, bathing, dressing and nappy changing, was still a part of the child's care despite hospitalisation. The report did not make it clear, however, whether the omission of such tasks from an analysis of paediatric dependency was based on an assumption that these tasks were carried out mainly by parents. In fact parental involvement in the care of the hospitalised child was not mentioned in the report at all. This deserves comment because in 1961 the North Canterbury Hospital Board would have received the questionnaire from the New Zealand Health Department, sent to all hospital boards in the country. This questionnaire sought to establish the extent to which boards were complying with the recommendations of the Platt Report. The extent to which mothers were involved in the care of their sick children was one of the categories under which information was requested. Findings indicated that there was a move towards unrestricted visiting for parents

⁴³ *Patient-Nurse Dependency Paediatrics*, Wellington, 1963, p. 13.

and in some instances the presence of the mother at meal times and bedtime was encouraged. This suggests that varying degrees of parental presence would presumably have been a feature of the paediatric ward environment in 1963. In omitting the role that parents may or may not have played in the care of the hospitalised child, the report therefore, failed to capture the extent to which parental presence either decreased or increased paediatric dependency.

Christchurch was also the location of a 1963 conference for professional groups organised by the Canterbury Mental Health Council as a contribution to the World Mental Health Year in 1961. The conference proceedings were published as a book entitled *Mental Health and the Community*. The conference papers covered six broad categories: 'foundations and development of healthy personality', 'nursing', 'education, character and faith', 'maladjustment, punishment and the law', 'counselling and psychotherapy' and 'organisation of services, training and research'.

In the second chapter of this book, Dr. Thomas Stapleton, Professor of Child Health at the University of Sydney, addressed the child's first year of life and was concerned with the healthy development of personality. In a vein similar to that taken by Moncrieff in 1961, Stapleton began by suggesting that in today's world children on the whole developed physically healthy, despite being nurtured in a variety of ways. He was, however, quick to point out that growing up mentally healthy did not depend solely on the specific type of physical nourishment given in the first year of life.⁴⁴ He suggested that, despite medical ignorance of the importance of early emotional development, the world had continued to turn merely because the mother appeared to be intrinsically suited to protecting and meeting her child's needs at this most vulnerable stage.

⁴⁴ T. Stapleton, 'The first year', in P.J. Lawrence, (ed.), *Mental Health and the Community*, Caxton Press, Christchurch, 1963, p. 50.

Such a situation, in Stapleton's view, could not be left any longer to the 'instincts' of the mother. He issued the following caution:

If we like, we may continue to leave the task of infant care to the mother, whose capacity does not rest on knowledge but comes from a feeling or attitude which she acquires as pregnancy advances, and which she gradually loses as the infant grows up.⁴⁵

Stapleton's comments concerning the mother's instinctive responses to her child's needs would appear to be consistent with the mothering style implicit in McKinlay's 'motherhood as service' paradigm discussed earlier. It was McKinlay's contention that just as this paradigm blurred the boundaries between mother and child it also began to blur the boundaries between mothers and experts.⁴⁶

Stapleton does indeed express sentiments that reflect the ideologies of the 'service' paradigm. I would argue, however, that according to him a woman's expertise as a mother was not the result of any actual knowledge. Considering the mother as an 'expert', therefore, would probably have seemed a misnomer, if the notion of 'expert' incorporates specialised knowledge. Consequently, questioning the boundaries between himself and a mother, as experts, would not have been possible.

In a later chapter Stapleton turned his attention to nursing the sick child in hospital. In his opening remarks he highlighted that current practice suggested that, whenever possible, admission to hospital should be avoided and the sick child should be nursed at home. He assumed that the majority of mothers would prefer to have their child at home when sick. Mothers were urged, if able, to put their children first and not their work. His following comment implied, however, that mothers generally were unable to do this and as a result this could precipitate illness in the child. He asserted that "one thing that every mother and every nurse should know, is

⁴⁵ T. Stapleton, 'The first year', p. 51.

⁴⁶ R. McKinlay 'Motherhood and self-definition in New Zealand, p. 139.

that quite often a child may have to be ill in order to get extra special attention from his mother”.⁴⁷

He then moved to a discussion of the child in hospital. He highlighted the recently published Platt Report and noted that the considerable change in attitude to the care of children in hospital in recent years had been as a result of the teachings of Sir James Spence, Dr. John Bowlby and Dr. D. Winnicott. Stapleton then traced the gradual liberalisation of visiting policies over the years and concluded that this had resulted in considerable changes in the nurse’s role, particularly that of the ward sister. He emphasised that ward sisters must not consider themselves as substitute mothers. Instead they were professional people and should be concerned with those tasks that mothers were unable to carry out.⁴⁸

On the one hand Stapleton’s comments appeared to support parental involvement in the care of the sick child. For example, he went on to point out that “nurses very soon come to realise that a large part of the child’s treatment is treatment of the parents, giving them education and reassurance; the parents being the best people to give the child the personal care he needs”.⁴⁹ On the other, he portrayed an entirely professionally centred view of care and offered scientific justification for allowing such involvement. He noted that “there are two gains to be derived from encouraging the presence of mothers in a children’s hospital. First, the psychological benefit to the child and, secondly, the chance to educate the mother”.⁵⁰ Stapleton’s observations offered a view of parents as performers of tasks, their role subordinate to that of the professional. “Their presence at meal times is particularly valuable for they learn, by

⁴⁷ T. Stapleton, ‘Nursing the sick child’, in P.J. Lawrence, (ed.), *Mental Health in the Community*, Caxton Press, Christchurch, 1963, p. 136.

⁴⁸ T. Stapleton, ‘Nursing the sick child’, p. 138.

⁴⁹ T. Stapleton, p. 142.

⁵⁰ T. Stapleton, p. 142.

seeing for themselves, what foods they should give their children”.⁵¹ These observations showed little appreciation of parental competence or expertise prior to the child’s hospital admission. Once again a boundary was drawn, albeit implicitly, between ‘expert’ professional and ‘inexpert’ parent.

Nancy (Nan) Kinross offered a response to Dr. Stapleton’s comments. At the time Nan Kinross was Matron of the Southland Hospital Board and had recently returned from a study tour of the USA and Canada. Perhaps influenced by this tour, her initial comments suggested that New Zealand nurses had not fully developed their role with regard to patient care. She indicated that the therapeutic and supportive role of the nurse was well recognised overseas. However, for this to be achieved in New Zealand Kinross argued that there needed to be a change in attitude toward what it was that nurses needed to know. She noted that “not only do they [nurses] have a certain technical knowledge, and carry out what doctors prescribe for the patient, but also there are certain things which they can do for patients which nobody else can”.⁵²

Nursing the sick child was an area that Kinross believed was well suited to realising the therapeutic and supportive role of the nurse. She conceded, however, that nurses had not always been receptive to the presence of parents in the children’s wards, and acknowledged that changes were needed in the nursing curriculum. Kinross noted that “there has not been sufficient emphasis on the importance of the dynamics of children’s behaviour and the behaviour of mothers and parents”.⁵³ She went on to describe how nurses overseas were working with groups of mothers and taking part in therapy in the children’s wards of psychiatric hospitals. The emphasis there was on working with the family and as a consequence medical, nursing and social work staff all had a greater awareness of how

⁵¹ T. Stapleton, p. 142.

⁵² T. Stapleton, p. 149.

⁵³ T. Stapleton, p. 150.

the child and family behaved. She admitted that this example seemed somewhat idealistic when considered in terms of current paediatric nursing practice in New Zealand.

Problems instituting such approaches in New Zealand nursing practice appeared to be pragmatic rather than ideological. Kinross pointed out:

Many of our difficulties arise from the fact that we have insufficient staff and that, moreover, we rely heavily on student staff. The use of case-assignment nursing in children's wards would be ideal, but this requires much greater supervision by senior staff of the more junior students.⁵⁴

Kinross's concluding remarks could be seen as a response to Stapleton's earlier observations concerning the changing role of the nurse in the children's ward. In his estimation one of the benefits of having mothers present was the opportunity that it provided to educate them. Communication was therefore, regarded as one-way from professional 'expert' to 'inexpert' mother. However, Miss Kinross's remarks highlighted that nursing needed to be concerned not just with the 'doing-to' but also the 'doing-with'. She stated that

ideally, it would appear that while the nurse should carry out her professional responsibilities and the tasks which the mother cannot or is unwilling to undertake, she should play a supportive role in supporting the mother in the care of her own child, whether at home or in the hospital.⁵⁵

Medical opinion about the perceived benefits of parental presence in the children's ward and advice for nurses on how best to capitalise on that presence also appeared in New Zealand paediatric nursing textbooks in the 1960s. In 1964 Dr. J.M. Watt wrote *Practical Paediatrics: A Guide for*

⁵⁴ T. Stapleton, p. 150.

⁵⁵ T. Stapleton, p. 152.

Nurses. In one chapter of this text the nurse was offered a glimpse of the developing debate over hospital care of the sick child. Entitled somewhat ironically 'Behaviour Problems', Watt outlined the emotional effects of hospitalisation on the pre-school child. He mentioned the work of James Robertson and suggested that the advice contained in his book *Young Children in Hospital* was admirable for dealing with the emotional trauma experienced by the hospitalised child. He listed the three main suggestions from that book:

- 1) That the ultimate aim should be admission to hospital of the mother with her sick child.
- 2) Failing this that visiting to the ward should be unrestricted, and parents should be encouraged to undertake non-medical care of their children.
- 3) That each nurse should be fully responsible for all the nursing of a small group of children, rather than for part of the nursing of all children.⁵⁶

Although he appeared to endorse this new approach to the hospital care of the sick child, Dr. Watt did not provide the reader with information or examples of whether practice, such as suggested by James Robertson, was occurring in New Zealand. In fact, nearing the end of the chapter he stated that "despite our best efforts admission to hospital *must remain* an unpleasant experience for a small child" [my emphasis].⁵⁷

In 1965 the New Zealand Health Department issued a pamphlet entitled 'You and Me' offering advice to parents whose child was to be admitted to hospital. Advice was supplied under the headings of 'preparation', 'what to take', 'visiting', 'don't be a worrier' and 'be honest'.⁵⁸

⁵⁶ J.M. Watt, *Practical Paediatrics-A Guide for Nurses*, N.M. Peryer, Christchurch, 1964, p. 144.

⁵⁷ J.M. Watt, p. 144.

⁵⁸ New Zealand Department of Health, *You and Me*, Wellington, 1965, Alexander Turnbull Library, pamphlet No. 107.

It was suggested to parents that preparing their child for admission to hospital should not start too early. Perhaps as a response to the findings of the Health Department's questionnaire to hospital boards in 1961, the advice to parents regarding visiting was equivocal. The pamphlet noted that "in some hospitals you may visit your child every day at times most convenient to you".⁵⁹ However, the following information indicated that parents could expect to be allowed to undertake some of their child's care while in hospital. It stated that "you will find that the nurses allow you to give some of the care yourself, such as helping your child wash, or assisting at mealtimes".⁶⁰ Finally, parents were urged not to be worriers. In fact the advice indicates that any expression of worry could exacerbate their child's illness and was needless because admission to hospital implied a transfer of responsibility for the child from the parent to the hospital.

You have taken your child to a doctor.

You have acted upon his advice.

Concern and worry will only be transferred to your child.

Don't subject him to this additional strain. He is going to hospital so that he may become stronger; surely that is reason enough for you not to be over-anxious.⁶¹

The physical surroundings and staffing needed in order to provide paediatric care of an optimum standard was the topic of two articles in the *New Zealand Medical Journal* in 1966 and 1968. The 1966 article, entitled 'Children in hospital', was written by Dr. A.E. Dugdale, Senior Lecturer in Child Health at the University of Queensland, Australia. He began by outlining that children's wards in New Zealand were usually attached to general hospitals. He went on to question the merits of such arrangements and pointed out that they were not common in other countries. His premise was that "each child in hospital should receive the best care that the

⁵⁹ *You and Me*.

⁶⁰ *You and Me*.

⁶¹ *You and Me*.

community can reasonably give”.⁶² He therefore, concluded that in the larger cities this could be best realised in autonomous children’s hospitals or units. Dugdale also suggested that ‘care’ within a children’s ward could be subdivided and classified in descending order of importance. Nursing staff were placed at the top of his list. He put forward the case for nursing specialisation in paediatrics and argued that the techniques and skills required were distinct enough to warrant this. He referred to current practice where nurses were seconded, often grudgingly, to the children’s ward for short periods of time from adult wards. Under such circumstances best practice standards could not be achieved. He reiterated the importance of having knowledgeable and experienced nursing staff in the children’s ward and drew the following analogy:

It is salutary to think that kindergarten teachers are given a three-year course before their knowledge of children is considered adequate, but nurses are expected to know the same after a few lectures and a month in the children’s ward.⁶³

Dugdale also pointed out that the number of nursing staff required in a children’s ward was greater than for an adult ward of the same size. The feeding, handling and changing of children was one particular aspect of nursing care in the children’s ward which Dugdale highlighted as essential but time-consuming. The invisible nature of such care was implied when he suggested that it often came under the heading ‘Tender Loving Care’. He conceded that mothers might be able to carry out many tasks for their children. However, he remained sceptical and asserted that “in general these duties cannot be delegated to untrained personnel, as the observations of a trained children’s nurse often play a large part in diagnosis and treatment”.⁶⁴

⁶² A.E. Dugdale, ‘Children in hospital’, *New Zealand Medical Journal*, 65, 4, January 1966, p. 4.

⁶³ A.E. Dugdale, ‘Children in hospital’, p. 4.

⁶⁴ A.E. Dugdale, p. 4.

Similar themes were covered in a 1968 article for the *New Zealand Medical Journal*, by Dr. R.H. Caughey, Children's Physician at The Princess Mary Hospital for Children in Auckland. Caughey maintained that despite the hospital being the only children's hospital in New Zealand, it did not meet best standards for the care of hospitalised children. He did not elucidate on the causes of such a failure.⁶⁵

Like Dugdale, Caughey believed that children's hospitals should be autonomous, although he favoured their development within the complex of a general hospital. He emphasised the need for maintaining standards of care in medical, nursing and paramedical fields. With perhaps reference to the current difficulties in maintaining standards of care he referred to the 1957 Report of the Royal College of Physicians of London on the Care of Children in Hospital which stated that

it is unnecessary and undesirable to attempt to provide a children's unit in every general hospital or even every area hospital. It is essential that the emphasis should be on the best treatment for children and the best training for those that are responsible for the medical and nursing care of children and this implies some concentration of children's beds.⁶⁶

Medical discourse concerning the psychological needs of the hospitalised child was not confined solely to the pages of medical and nursing journals. In November 1969, the *Parents Centres Bulletin* published an address given to the Dunedin Parents Centre in 1968 by Dr. Patricia Buckfield from the Paediatric Department, Queen Mary Maternity Hospital, Dunedin. In her opening remarks Buckfield emphasised the importance of an appropriate understanding of children's emotional needs when caring for the young child in hospital. She went on to outline what was considered to be normal early development in the child under five years old. She noted

⁶⁵ R.H. Caughey, 'The children's hospital of the future', *New Zealand Medical Journal*, 68, 120, August 1968, p. 120.

⁶⁶ R.H. Caughey, p. 120.

that “it is believed to be important – even essential – for mental health that an infant should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment”.⁶⁷ Although she did not attribute these comments to Bowlby, those familiar with his monograph *Maternal Care and Mental Health* would have recognised him as the source.

Later in the article Buckfield turned her attention to the effects of separation on the two and three year old child. She suggested that the emotional response to separation from the mother in this age group could be just as severe and cited Robertson’s contention that children’s reactions commonly passed through three stages: protest, despair and denial.⁶⁸ After outlining these stages in more detail Buckfield posed a rhetorical question: “why have we been so tardy in accepting the dangers of solitary hospitalisation of the infant?”⁶⁹ She answered her own question by suggesting that the initial distress suffered by the infant was viewed as inevitable, and consequently was assumed to be unimportant. After this initial agitation most children became happy and manageable which lulled hospital staff into believing that parents were no longer missed and that the child was not harmed by these experiences.⁷⁰

Buckfield deemed admission of the mother with her child as the solution to preserving continuity between home and hospital for the child under four or five years old. She believed that the mother should continue as much of the routine care of her child as she was able to in the hospital. She cautioned that for this approach to care to be successful, staff must be convinced that the mother was the preferred person for a child. Again Bowlby’s theory provided necessary ‘expert’ justification for mothers’

⁶⁷ P. Buckfield, ‘The child in hospital’, *Parents Centres Bulletin*, No. 41, November 1969, p. 4.

⁶⁸ P. Buckfield, p. 5.

⁶⁹ P. Buckfield, p. 6.

⁷⁰ P. Buckfield, p. 6.

continued presence, as Buckfield pointed out that “the staff should clearly understand that the basic principle in her presence is to protect the social and emotional development of the child and is not just a means of making him less miserable”.⁷¹

Arguably such a stance was taken to ensure that mothers were viewed as more than rivals or added complications. They had a definitive role in the hospital care of their child. I suggest, however, that ‘expert’ justification for the presence of mothers in the children’s ward, albeit unwittingly, served to place upon all mothers an expected standard of ‘good’ mothering against which all mothers would be judged. However, Buckfield acknowledged that mothers should not be compelled to stay in hospital with their child. She emphasised that the opportunity should be there and the advantages pointed out to them. The final decision, however, rested with the parents and they should not be reproached for it. It is interesting that Buckfield promoted case-assignment nursing as the remedy for when the mother could not be there.⁷²

Summary of 1960s professional rhetoric

This review of available New Zealand nursing and related literature during the 1960s suggests that both nursing and medical rhetoric at this time reflected and arguably fuelled the wider societal concern for the young child’s psychological development and the mother’s responsibility for that development. The experience of mothering during this time period was defined by the context of ideas and beliefs about children. Motherhood was a totally child-centred way of being. It had shifted, as McKinlay suggested “from a public duty to a private responsibility”.⁷³ Mothering was a responsibility located and carried out within the confines of the home. This suited the agendas of those opposed to mothers working outside the home and provided scientific justification for refusals to

⁷¹ P. Buckfield, p. 6.

⁷² P. Buckfield, p. 8.

⁷³ R. McKinlay, ‘Motherhood and self-definition in New Zealand’, p. 155.

provide day care for children. However, the literature has indicated that promotion of this mutually exclusive relationship between mothers and their children appeared to be problematic when applied to the hospital environment. Calls for change to hospital policy that would allow parents freer access to their children and for mothers to live-in with their sick child were the consequence of an ideological shift which deemed the mother essential for the emotional health and wellbeing of her child. The medical and nursing literature supported this ideology and mothers' increasing presence in children's wards was explained in terms of the needs of the child. However, medical and nursing commentary expressed differing points of view as to how mothers would conform to the hospital environment and how staff would respond to them. Medical commentary was at pains to point out the difference between the 'expert' professional and the 'inexpert' parent. On the other hand nursing commentary favoured a more egalitarian relationship between professional and parent. Having explored the professional rhetoric, the next section of this chapter considers the parents reality.

Parental reality

This section examines the extent to which the espoused nursing and medical rhetoric concerning the increasing presence of mothers in the children's wards influenced the reality of a mother [Mary] whose child was admitted to one New Zealand hospital in the 1960s. Mary's account suggests that two significant factors shaped this reality: hospital-imposed rules and her response to them, and expectations of her role within the hospital setting. This experience is related to prevailing ideas presented in professional literature of the time.

Mary recalled the shock of being told that her seven-year old son Peter required hospitalisation. The diagnosis of Perthes disease, characterised by an impairment of the blood supply to the femoral head, indicated that it would be a protracted admission. Peter was admitted initially for three

months and then discharged. Mary remembered that “we were expected to keep him in a wheelchair, not to let him walk which was virtually impossible particularly as it was over the Christmas holiday period. He was readmitted three months later and was there for the next thirteen months”.⁷⁴

Abiding by the rules

Mary’s experience of her son’s sixteen-month hospitalisation could be best characterised by her recurrent use of the phrase ‘abiding by the rules’. Although much of the medical, nursing and related literature at the time endorsed the trend towards unrestricted visiting for parents, Mary’s reality proved to be quite different. She explained that “we had to abide by the visiting hours, there were none or very few concessions made due to the fact that he was going to be there for such a long period of time”.⁷⁵ The literature has indicated that changes to hospital visiting policies were the result of concern about the effects of separating the young child from its mother. I speculated that Mary’s son, at seven, was outside the age range where daily visiting would have been considered essential. Reflecting on this Mary noted, “I can’t remember a lot of other parents being there in that area where he was, on the balcony...I can remember parents in other sections, parents of babies.”⁷⁶

Peter was part of a large family. He had four older sisters and two younger brothers. Both Mary and her husband were concerned that this prolonged hospitalisation would isolate Peter from his family. Acting on this concern for Peter’s emotional well being, Mary’s husband approached the physician in charge of the paediatric department in the hope that some concessions to the restrictive visiting hours could be made. Mary recalled that unfortunately none were forthcoming, although she explained that “as time

⁷⁴ Oral history interview with Mary, 18 September, 2001.

⁷⁵ Oral history interview with Mary, 18 September, 2001.

⁷⁶ Oral history interview with Mary, 18 September, 2001.

went on that [visiting] was perhaps made a little easier”.⁷⁷ Prevented from visiting her son at times convenient to her, it is not surprising that she described visiting the hospital as “a duty that had to be fitted into the demands of the day”.⁷⁸ Enforcement of prescribed visiting hours in children’s wards reflected an assumption by professionals that the mothers only concern would be the needs of her sick child. No thought was given to how she might accommodate the needs of her other children. This contention was illustrated by Mary’s following description of how she would juggle visiting Peter:

I was so busy and focused on other things you know I always had in my mind when I was visiting what I had to do as soon as I left. I had two pre-schoolers. I would have to have someone to look after the children while I went. I had a person who helped in the house who was willing sometimes to stay on so that I could go to the hospital, if not I would have to leave the eldest daughter in charge of the others while I went to the hospital.⁷⁹

Both she and her husband endeavoured to visit Peter each day, in Mary’s words, to “keep this child as part of a family situation”.⁸⁰ Ironically hospital rules precluded the rest of the family from visiting Peter. Mary remembered how frustrating it was that her two eldest daughters, who virtually cycled past the hospital on their way to secondary school, were not permitted to visit him. As she explained:

They would gladly have stopped off and read stories and visited, you know, done all those sorts of things which would have relieved us as parents a little, but no, that wasn’t permitted, certainly not between Monday and Friday. As the months went by and they were going to

⁷⁷ Oral history interview with Mary, 18 September, 2001.

⁷⁸ Oral history interview with Mary, 18 September, 2001.

⁷⁹ Oral history interview with Mary, 18 September, 2001.

⁸⁰ Oral history interview with Mary, 18 September, 2001.

music in the city centre on a Saturday morning, they would sometimes try and get a quick visit on their way home.⁸¹

Inflexible and strictly enforced visiting hours have been one way in which hospitals historically have maintained lines of demarcation between them and the outside world.⁸² Stacey has described established visiting hours as a time when the hospital was “on show”.⁸³ Illustrative of this is Mary’s description of visiting hours. She recalled:

I have a feeling a bell rang. I think there was some sign that either visiting was beginning or ending. The nursing staff were not busying themselves about while it was the time for visiting but when that finished then they would come back again and you had the feeling that yes, you had to disappear.⁸⁴

Breaking the rules

Mary explained that as Peter’s admission continued, inventive measures with regards to visiting Peter were called for. However, breaking the rules was never blatant. “When he was out on the balcony I could sneak a bit, you know, and if I remember rightly I’m not sure whether I always had to walk through the ward or whether I learnt to come up the back steps.”⁸⁵ Arguably ward staff would have been aware that this parental subterfuge was taking place. It appeared to be tolerated because it was covert and did not openly challenge the restrictions imposed on parents by the professionals. However, Mary remained acutely aware of the fine balance between ‘abiding by the rules’ and ‘breaking the rules’. She remembered:

⁸¹ Oral history interview with Mary, 18 September, 2001.

⁸² See E. Goffman, *Asylums* Peregrine Books, London, 1987, and M. Stacey, ‘Introduction’, in Stacey, M. (ed.), *Hospitals, Children and their Families- The Report of a Pilot Study*, Routledge & Kegan Paul, London, 1970.

⁸³ M. Stacey, p. 7.

⁸⁴ Oral history interview with Mary, 18 September, 2001.

⁸⁵ Oral history interview with Mary, 18 September, 2001.

If we were going to a dress up function or to a ball we would try to sneak in for five minutes because he [Peter] wanted to see both his Dad and I dressed up. We did that a few times but not often. We couldn't afford to get off side with the administration that's for sure.⁸⁶

Mary and her husband found other more subtle ways to circumvent hospital rules that gave Peter the opportunity to spend time with his brothers and sisters. For instance, Mary described that “we would take the children into the church service on a Sunday and take him [Peter] down on his bed to the chapel just so they could all be together for an hour or so”.⁸⁷

‘Expert’ professional - ‘Inexpert’ parent

The literature has suggested that professional staff supported increased parental presence in the children's wards as long as they could determine what the parent would do when present. Mary recalled that during Peter's sixteen-month admission she had done nothing more than ‘visit’. She explained that “I had none [involvement in care] whatsoever. I can't recall having done anything other than visit, which sometimes wasn't terribly satisfactory”.⁸⁸ Mary was not aware at the time of a movement urging hospitals to allow parents unrestricted access to their sick children. She felt that the attitude of the staff mellowed as the months went by and, during the interview, she wondered whether that was because the staff knew about this new approach to children's care.

In the context of the ward environment medical staff drew the boundary between the ‘inexpert’ parent and the ‘expert’ professional more explicitly. Mary still remembered the attitude of the doctor on the day Peter was admitted. She told me that “when he [Peter] was admitted the registrar came to me with a sheaf of questions, foremost among them ‘what did you

⁸⁶ Oral history interview with Mary, 18 September, 2001.

⁸⁷ Oral history interview with Mary, 18 September, 2001.

⁸⁸ Oral history interview with Mary, 18 September, 2001.

take’”⁸⁹ This view assumed that Mary had taken medication during her pregnancy and, consequently, was detrimental to her child’s health. Admission to hospital would provide the cure and implied a shift in responsibility for the child’s welfare from parent to professional. As Mary pointed out, “we would have considered that his [Peter’s] welfare definitely would be handed over. We had no input whatsoever into the treatment and so we had to be guided by the professionals who said this is what has to happen”.⁹⁰

Although Mary told me that she had no expectation of involvement in Peter’s hospital care, paradoxically as a mother intimate involvement in the care of ones child was a given. Mary’s account of ‘juggling’ other family responsibilities in order to visit Peter everyday reflected this on-going intimate involvement. Arguably, however, because Mary was not involved in the ‘expert’ care of her hospitalised child, professional staff disregarded the energy and effort required of Mary to maintain contact with her son. She told me that “I would just like them to have been a little more responsive to my life as it was, that I had other obligations to my other children as well.....the system seemed to be so rigid that there was just no accounting for anything other than that”.⁹¹

Access to information regarding Peter’s care was another way in which medical staff maintained the boundary between ‘inexpert’ parent and ‘expert’ professional. Mary recollected, “Oh no we were never involved in decision making. If on a Saturday morning we were there and the surgeon did his rounds you might have heard a little bit but it was never anything other than ‘oh he’s doing alright’”.⁹² The nursing staff were described by Mary as “very nice...very sympathetic”.⁹³ Even the sister in charge, who

⁸⁹ Oral history interview with Mary, 18 September, 2001.

⁹⁰ Oral history interview with Mary, 18 September, 2001.

⁹¹ Oral history interview with Mary, 18 September, 2001.

⁹² Oral history interview with Mary, 18 September, 2001.

⁹³ Oral history interview with Mary, 18 September, 2001.

had been, in Mary's words, "very strict in the beginning"⁹⁴, appeared to alter her attitude after several months and Mary remembered that they became quite friendly. She also indicated that Peter and she were 'popular' with the nursing staff. This was tempered, however, by the following comment from Mary when she said, "unless he [Peter] played up which occasionally happened when there were two or three boys of much the same age side by side in traction".⁹⁵

Mary's description of the nursing staff as 'sympathetic' is of interest because it indicates that there may well have been a degree of agreement and understanding shown by the nursing staff toward parents as they sought to find ways round the restrictive hospital rules that governed access to their children. However, it appeared that nursing staff had no authority to relax or change the rules when, rather ironically, they were charged with enforcing them. This view of nurses as peripheral to any debate or discussion concerning liberalising parental access to the children's ward was highlighted by the actions of Mary's husband. He went to the doctor in charge of the paediatric department instead of the ward sister, seeking concessions to prescribed visiting hours.

This points, as does the literature reviewed earlier in the chapter, to the hegemony of medical staff. Doctors held firm professionally centred opinions on the reasons why parents should or should not be allowed more liberal access to the children's wards. Their opinions also extended to the nature of nursing the sick child and there was a medical prescription for the role that the mother and the nurse would adopt. As the literature has shown, nursing commentary that challenged these opinions was scarce. The next section examines the reality for nurses.

⁹⁴ Oral history interview with Mary, 18 September, 2001.

⁹⁵ Oral history interview with Mary, 18 September, 2001.

Nursing reality

This section examines the extent to which the espoused nursing and medical rhetoric concerning the increasing presence of mothers in the children's wards influenced the reality of one nurse, [Helen], who worked in a New Zealand hospital children's ward in the 1960s. Her experience indicates that the published professional nursing and medical rhetoric did not match the nursing practice reality. While some changes were made within the children's ward, these did not reflect a wholehearted acceptance of the new views.

Going to the children's ward

Helen's first memories of nursing in the children's ward were as a senior nurse in the 1950s. She remembered being assigned to work in the babies' ward which housed children up to two years of age. Helen noted that during her training days there was only Sunday visiting for parents and she recalled conversations with other colleagues about what it was like at the end of visiting hours. She remembered that "they were just all so upset and in the older children's ward one nurse said they went round with a jar of Aulsebrooks toffees to give the children to quieten them down after the parents had left".⁹⁶

Learning more about babies

After leaving the babies' ward Helen completed her six-month maternity training and stayed on as a nursery sister at the hospital. "I was there a year so I got quite good at babies up to two weeks of age. The babies certainly weren't nursed alongside the mothers. The babies were all kept in the nursery and just taken out for feeds and then the mothers were taught how to bath them before they took them home and that was that really".⁹⁷

⁹⁶ Oral history interview with Helen, 5 October, 2001.

⁹⁷ Oral history interview with Helen, 5 October, 2001.

Maternity nursing stimulated Helen's desire to learn more about caring for babies over two weeks of age. She therefore, made the decision to undertake the Plunket training. Helen noted that at the time nurses could be sponsored by the Plunket Society, a hospital or the District Nursing Service. She approached all of them and recalled that the matron's response at her training hospital was "if you go and do the Plunket training you'll be through it by August 1957 and the ward sister in the babies' ward is leaving to be married so you can have the job".⁹⁸ In the previous chapter I mentioned the bursary system for Plunket training referred to in 1953 by Miss Flora Cameron, Director Division of Nursing New Zealand Health Department. These bursaries were important as Plunket training was expected for nurses in many practice settings. When describing the acceptable standards of a paediatric nursing service Cameron noted that "all sisters in charge of paediatric wards, all sisters in obstetrical hospitals, and all public health nurses receive this training".⁹⁹

In charge of the babies' ward

Helen took up the post as ward sister of the babies' ward nearing the end of 1957. She recalled that although she had not had any specific training for the post of ward sister, the Plunket training certainly boosted her confidence. To illustrate this Helen pointed out that "we did have a lot of 'failure to thrive' coming in and I knew about infant feeding.....it was very much the Plunket system, very regimented, very exact in the way you introduced the milk mixtures and the powdered milk".¹⁰⁰

Helen could not recall any mothers breast feeding their babies. Rather she remembered a row of bassinets flanking a long balcony. This area would be staffed by a Karitane nurse each shift.¹⁰¹ She pointed out however, that

⁹⁸ Oral history interview with Helen, 5 October, 2001.

⁹⁹ F.J. Cameron, 'Acceptable standards of paediatric nursing service', *The New Zealand Journal of Nursing*, October 15, 1953, p.148.

¹⁰⁰ Oral history interview with Helen, 5 October, 2001.

¹⁰¹ These nurses were trained by the Plunket Society to care for babies. They were not registered maternity nurses and could not therefore, become Plunket nurses.

there was no accommodation for mothers to live-in anyway. Despite this situation Helen maintained that the mothers did not seem to get upset.

About 1958 changes to the visiting hours in the children's ward were made in the hospital. Helen explained that "the visiting hours changed to daily but only in the afternoons, there was never any evening visiting that I remember, I don't remember the fathers coming in after work".¹⁰² This year also heralded changes in the medical staff appointed to paediatrics in this particular hospital. Until this time the paediatric service had been under the medical guidance of an adult physician who worked only part-time in paediatrics. The appointment of a New Zealander fresh from paediatric training in England was considered a 'godsend'. As Helen recalled:

When he did come everything changed really.....He came straight from England with a lot of new ideas and introduced new techniques and investigations and I just feel that modern paediatrics took off from that day and it was really quite an exciting era to be a part of.¹⁰³

Going overseas

Helen was always keen to update and increase her knowledge in paediatric nursing. It was therefore, not surprising that overseas travel beckoned when she heard about a thirteen-month experimental paediatric nursing course conducted by The Hospitals for Sick Children, Great Ormond St. London. She completed the Registered Sick Children's Nurse (RSCN) training between 1961 and 1962. Reflecting on her training in London, Helen said:

I didn't hear anything about the Platt Report. I just remember the incredible difference in a children's hospital versus a children's ward in a general hospital. There (Great Ormond Street) they had three

¹⁰² Oral history interview with Helen, 5 October, 2001.

¹⁰³ Oral history interview with Helen, 5 October, 2001.

nurses for ten patients and three night nurses for twenty and one at the most two consultants to a ward of twenty.¹⁰⁴

It is hardly surprising, given the recommended standards for staffing children's wards in New Zealand, that Helen remembered with some clarity the variation between the two. In a 1953 article written for the *New Zealand Nursing Journal*, Cameron had discussed staffing requirements for children's wards in New Zealand. She noted that "ward staffing is also important. In a children's ward of thirty beds we have a minimum of one sister, two staff nurses (one on each duty), four student nurses on each duty and two night nurses".¹⁰⁵ New Zealand nursing and medical discourse did not begin to address the issues of staffing in children's wards until the early 1960s. In 1963 Nan Kinross offered the shortage of nursing staff and the heavy reliance on student staff as the reason why case assignment nursing had not yet been instituted in New Zealand children's wards.¹⁰⁶

Changes and challenges

Helen returned to New Zealand after three years overseas. She came back equipped with her RSCN qualification, to find that the older children's ward in the hospital she had left three years earlier was without a ward sister.

I had never had anything much to do with the older children and I had been at the Hospitals for Sick Children Great Ormond Street where everything was just so well run for children and then I had to take over this ward which was incredible.¹⁰⁷

Helen now faced the challenge of running a busy children's ward that had been without a nursing leader for some time. Other challenges presented themselves in part due to the changes, particularly in visiting hours, that had occurred in the time Helen had been away. She recalled that "visiting hours had certainly been increased for parents and they were visiting from

¹⁰⁴ Oral history interview with Helen, 5 October, 2001.

¹⁰⁵ F.J. Cameron, 'Acceptable standards of paediatric nursing service', p. 147.

¹⁰⁶ T. Stapleton, 'Nursing the sick child', p. 150.

¹⁰⁷ Oral history interview with Helen, 5 October, 2001.

11am until 6pm”.¹⁰⁸ Helen felt sure that the paediatrician in charge of the children’s department had instituted these more liberal visiting hours. In principle Helen supported the move to allow parents greater access to their hospitalised child. However, the effect of such a change for nursing practice was something Helen had to grapple with on a daily basis.

While I recognised that it was wonderful for the children and the parents it certainly wasn’t an easy thing for somebody running the ward. You must remember in those days the only person who had been trained in paediatrics was, if you were lucky, the sister in charge of the ward and the paediatrician. Every nurse that came, came from an adult ward. She came to get her paediatric experience. When I was training mostly you stayed three months in a ward but between 1963 and 1967 the nurses were changing every three weeks.¹⁰⁹

Another change had occurred which also impacted on Helen’s role as ward sister. Medical students were now coming to the hospital as part of their training programme and, as Helen recalled ward rounds were really just very long teaching rounds. The ward sister’s attendance on these rounds was expected. The increasing busyness of this ward provided the impetus for Helen to highlight the issues facing nurses on a daily basis. She recalled the occasion when she went down to see the medical superintendent to express her concerns about the prospect of having even more children admitted following the appointment of a new surgeon. Helen remembered that the medical superintendent was relatively new and greeted her with the comment “I’ve never actually visited your ward I’ve got you down as a thirty-five bed ward”.¹¹⁰ Helen responded, “Well at the moment we’ve got fifty patients.”¹¹¹ Despite not visiting the ward on that

¹⁰⁸ Oral history interview with Helen, 5 October, 2001.

¹⁰⁹ Oral history interview with Helen, 5 October, 2001.

¹¹⁰ Oral history interview with Helen, 5 October, 2001.

¹¹¹ Oral history interview with Helen, 5 October, 2001.

day, Helen remembered that he did come down to the ward on a particularly busy day. She described the scene:

There were eight arranged patients waiting, the consultant paediatrician was doing a long ward round, there were theatre cases going up to theatre on trolleys everywhere, an acute admission had just arrived and there were beds down the middle of the ward, you could hardly bend over between the beds....he just couldn't believe it....he whirled into action then. He sent the eight arranged admissions home. They still appointed the new surgeon but things changed a little bit from then on.¹¹²

Helen also put her concerns in writing to the hospital administration in the form of an eight-page report. Written in 1965 it was given the rather lengthy title, 'Some Reasons why the Children's Wards need Special Consideration with Regard to Allocation of Staff and more Co-operation from Doctors and other Departments'. Particular mention was made of the increased staff quota required in the children's ward. Point nine of the report's first page explained that the ratio of nurses to patients should be higher in a children's ward because of extra help being needed for treatments, e.g.

- (a) pathology technicians need help to do all their hurtful procedures.
- (b) most nursing and medical treatments on children (dressings, lumbar punctures, examinations, throat swabs, etc.) require at least two nurses (and often take up to four nurses).
- (c) many procedures take longer to do because children have to be coaxed into submitting to things, e.g. T.P.R. taking, medicines and other ordinary procedures.
- (d) much more time is required in dealing with children, keeping them occupied and amused and comforted, especially on the departure of parents from a little child.¹¹³

¹¹² Oral history interview with Helen, 5 October, 2001.

¹¹³ Oral history interview with Helen, 5 October, 2001.

Helen followed this point by outlining the staffing ratios she encountered at The Hospitals for Sick Children in 1961.

Taken in context, point eleven of Helen's report highlights the increasing workload that extended visiting hours placed on ward sisters.

The prolonged visiting hours, while keeping up with present trends, are a tall order for the ward set up as it is at present with all the other traffic. The ward sister is constantly interrupted not only by mother in the morning, but father at lunchtime and, perhaps granny or auntie [sic] in the afternoon (when the latter shouldn't even be there at all).¹¹⁴

Helen's proposal for some modification to the visiting hours was made in point six of the report's 'suggestions' as follows:

Visitor's Suggest changing hours to 1pm–6pm Monday/Friday, 11am–6pm weekends.

At the sister's discretion, exceptions to be made for mothers staying in hotels or in Christchurch solely for the child's hospitalisation, and for upset children who need mother in for longer periods.

1pm–6pm Suggest in this case that other members of the family be allowed to visit but only two at a time and also siblings if no other arrangements can be made.¹¹⁵

Helen was certain that her report was responded to but she was unable to locate the response from the hospital administration. However, she was sure that the visiting hours were changed because she remembers things getting a bit easier. Reflecting on whether the change, which in fact amounted to a decrease in visiting hours, would have created difficulties for parents, Helen could not recall that there had been any parental objection. In fact she said

people in those days accepted the rules of the hospital, what they were told and what was expected of them. I can't remember them

¹¹⁴ Oral history interview with Helen, 5 October, 2001.

¹¹⁵ Oral history interview with Helen, 5 October, 2001.

complaining or making life difficult for us. They seemed to be grateful for what was being done.¹¹⁶

She did recall, however, that the main objection to the change in the visiting hours, had been to the number of visitors that were allowed round the patient's bed. She explained that "if I remember rightly they [parents] thought they should be allowed to have three or four around a bed".¹¹⁷

Where's mummy?

Restricting the visiting hours probably did impact on parents. Mary's experience of having to juggle both visiting Peter and the demands of her other children suggests this. Arguably, however, the impact would have been greater for the hospitalised child. Helen had memories of children in isolation being upset but she felt that generally most of the children in the ward were not unhappy. She illustrated her contention with the following comment. "For one thing with the open ward there was so much going on that if they were crying they soon stopped and there was so much traffic, there were doctors, nurses scurrying with trolleys and going in and out."¹¹⁸ This was also the era, Helen explained, when "the patient had come into hospital to be looked after and it was our job to look after him...it was the nurse's job to do everything for the child".¹¹⁹

It appeared that visiting hours had been restricted so that nursing staff could carry out their work in a more timely and efficient manner without interruptions from visiting parents. Although Mary had done nothing more than 'visit' during Peter's sixteen-month admission, she still described feeling like an 'interloper'. Parents were certainly not viewed as potential partners in the child's care and were in some instances regarded as impeding it. This view was expressed in the report written by Helen explaining the reasons why the current visiting hours should be decreased.

¹¹⁶ Oral history interview with Helen, 5 October, 2001.

¹¹⁷ Oral history interview with Helen, 5 October, 2001.

¹¹⁸ Oral history interview with Helen, 5 October, 2001.

¹¹⁹ Oral history interview with Helen, 5 October, 2001.

She pointed to one of the reasons in saying that “it is not unusual for visitors to indiscriminately feed other children, take them to the hospital shop without permission to leave the ward, or potty them and spoil a special collection”.¹²⁰

‘The right thing to do’

Even though the reduction in visiting hours probably meant that parents were further marginalised, nursing response to parents often appeared paradoxical. Helen expressed this in her use of the phrase ‘the right thing to do’. She remembered clearly an occasion when a young child was very upset in the evening and asked the child would he feel better if he could talk to mummy on the telephone.

I remember thinking then it was a very unusual thing to do. I actually rang the mother. I had to say, look there’s nothing wrong, he’s all right but he’s a bit upset and I’d just like him to hear your voice. I remember a doctor coming in and seeing this child talking on the telephone and he sort of raised his eyebrows, it wasn’t the usual thing, but the child settled down just hearing mummy’s voice.¹²¹

Helen also related a similar experience, which she described as “doing something that wasn’t the done thing”.¹²² She went on to explain that

this little child was about three and he just went totally silent. Although his parents were visiting he wasn’t talking. I suggested that we get his brothers and sisters in to talk to him, so we put him on the balcony and I’ll never forget the change in that child. He was talking to his brothers and sisters and it’s the memory I’ve got that it was the right thing to do.¹²³

It would seem that nurses were appreciative of family involvement for the child’s sake yet they had to be strict about the number of visitors and

¹²⁰ Oral history interview with Helen, 5 October, 2001.

¹²¹ Oral history interview with Helen, 5 October, 2001.

¹²² Oral history interview with Helen, 5 October, 2001.

¹²³ Oral history interview with Helen, 5 October, 2001.

enforcement of visiting rules. Helen's description of moving the child on to the balcony so that his brothers and sisters could visit is of interest. As Mary had described earlier, the balcony was away from the main ward area and not subject to constant scrutiny, which allowed her to 'sneak in'. Helen's decision to move this child suggests that nursing actions such as this also had to be covert. Reflecting on whether there had been any repercussions from this incident Helen said:

I don't remember coming under fire at all. I think the ward sister in those days had quite a lot of say, after all I was the one with the paediatric training as far as the nursing hierarchy went and I think they sort of accepted what I wanted to do if it was reasonable.¹²⁴

Helen only made mention here of the nursing hierarchy as accepting of practices that were out of the ordinary. It remains unclear as to whether the medical staff were as supportive of these autonomous nursing decisions.

Summary of parental and nursing reality

The experiences of Mary and Helen, while not able to be generalised as reflective of the experience of other parents or nurses in the 1960s, are illustrative of one hospital's response to the changing environment in the children's ward. When juxtaposed with the reviewed New Zealand nursing, medical and related literature during this time period, the gap between espoused theory and the realities of practice, particularly nursing practice, are apparent.

When seeking reasons for the restrictions and rigidly enforced rules that Mary encountered during her son's protracted hospitalisation I suggested that his age may have influenced this. However, Helen had no recollection of mothers of babies or younger children being allowed to stay or visit more often than parents of older children. As the literature has shown, there was a considerable amount of information published at this time in both professional and non-professional texts that referred to Bowlby's

¹²⁴ Oral history interview with Helen, 5 October, 2001.

maternal deprivation thesis and its applicability to the hospital environment. Ironically, Mary and Helen remained unaware of this growing trend.

Although Helen returned to the hospital to find that visiting hours had been liberalised, it appeared that this was tenable in so far as there was no disruption to the traditional ward routine. It could be argued that with extending the hours in which parents were allowed access to their children there could have been an appreciation and acknowledgement that the title 'visitor' was no longer an adequate or applicable term to describe the relationship between parents and their children. Mary and Helen's experiences have indicated that such issues were not openly addressed. The boundary remained between the 'expert' professional, whose job it was to care for the child, and the 'inexpert' parent accorded the status of 'visitor' for the duration of their child's hospitalisation.

Accordingly there was little appreciation of the impact that extending the visiting hours would have, particularly on the nursing staff. The literature made little mention of the effects that changes in visiting hours had or would have in children's wards. I would argue that Helen's decision to restrict visiting hours had little to do with whether or not she believed that parents should be excluded from their child's hospital care. Rather it was necessary because increased parental presence had an attendant increased workload for nursing staff and it was beginning to impact on their ability to meet established medical and organisational routines. These actions pointed to a professionally-centred view of care and an established hierarchy of individual importance in the ward environment. Medical staff were at the top and parents were at the bottom. Nurses were in the unenviable position of being caught between the two.

Motherhood redefined

By the early 1970s New Zealand society was witnessing the formation of new feminist organisations such as The National Organisation for Women and Auckland Women's Liberation. In 1972 the latter group launched the

feminist magazine *Broadsheet* and were also the driving force behind the first United Women's Convention in 1973.¹²⁵ As New Zealand journalist, Sue Kedgley, suggested in her book entitled *Mum's the Word*, all women to some extent were affected by the new ideas of the women's movement, whether they agreed with them or not.¹²⁶

Arguing for freedom of choice and equality of opportunity for women ultimately led to a certain scepticism of everything in a male-dominated society, not the least of which continued to be the polemic of separate spheres within marriage and the family. Rosemary Novitz has pointed out that the traditional dominance of men within the family contributed to an acceptance of male control in areas outside the family.¹²⁷ The early manifestos of the women's movement argued that motherhood was but one of many choices open to women, it was not their only choice. Responsibility for child rearing shifted from being the sole responsibility of women to a societal one. Accordingly, I would speculate that as women began to question traditional male dominance in the home, they also realised that areas of traditional male dominance in the public arena were also open to challenge. A plea for rooming-on facilities in hospitals was one of several issues presented by women at a conference on 'Women and Health' in 1977. This conference gave women the opportunity to highlight and challenge the traditional hierarchy and dominance of medicine within hospital systems.¹²⁸

Other forums also challenged the doctrine of Bowlby and Robertson, affirmed unequivocally since the 1950s, that pre-school age children would

¹²⁵ G. Dunstall, 'The social pattern', in Rice, G. (ed.), *The Oxford History of New Zealand*, Oxford University Press, Auckland, 1992, p.481.

¹²⁶ S. Kedgley, *Mum's the Word*, Random House, New Zealand Ltd., 1996, p. 238.

¹²⁷ R. Novitz, 'Marital and family roles in New Zealand: The challenge of the women's liberation movement', in Koopman-Boyden, P.G. (ed.), *Families in New Zealand Society*, Methuen, Wellington, 1978, p.73.

¹²⁸ P. Bunkle, *Second Opinion: The Politics of Women's Health in New Zealand*, Oxford University Press, Auckland, 1988, p.28.

suffer irreparable emotional harm unless their mothers were in constant attendance. In 1974 the Labour government convened a Select Committee on Women's Rights to investigate the changing role of women in New Zealand society. The results from Jessie Bernard's 1974 study of child rearing in six cultures revealed that communal child rearing benefited children. In contrast to the traditional Western model of child rearing that isolated the mother and child, Bernard found that communal child rearing provided an environment that was more loving and less stressful.¹²⁹ Margaret Mead also supported this view. In the foreword to Jane and James Ritchies 1978 book, *Growing Up in New Zealand*, she cautioned against placing too great an emphasis on the mother-child relationship compared with the importance of the community tie.¹³⁰

It appeared that the pendulum had begun to swing again and motherhood was redefined as one of many life experiences open to women. The effect that this paradigm shift would have in the context of the hospital children's ward, whose traditional practices had been challenged and changed based on Bowlby's maternal deprivation evidence from the 1950s, will be examined in the next chapter.

¹²⁹ J. Bernard, *The Future of Motherhood*, Dial Press, New York, 1974.

¹³⁰ J. Ritchie & J. Ritchie, *Growing Up in New Zealand*, George Allen & Unwin, Auckland, 1978, x.

CHAPTER 4:

Going to hospital with mummy: Rhetoric and reality of ‘family-centred care’.

In this chapter I draw again on the work of Robin McKinlay and Dugald McDonald to explore the changing ideas about mothering and childhood in New Zealand during the 1970s. New Zealand nursing, medical and related literature from the 1970s and 1980s, is used to explore the hospital care of children and the influence of ‘experts’ in matters of child health. Professional and public response is considered in relation to new societal attitudes towards mothering and children and their implications for the practice of ‘family-centred care’ in the context of the hospital children’s ward. Oral history interviews from one mother whose child was hospitalised in the 1980s, and one nurse who worked in the children’s ward of a New Zealand hospital at this time, reveal the contradictions in the practice of ‘family-centred care’.

The emerging paradigm of motherhood in the 1970s

Robin McKinlay has suggested that the Women’s Movement, during the 1970s, gave voice to the new emerging paradigm of motherhood. She has called this new paradigm “motherhood as life experience”.¹ Becoming a mother was one of many choices women could make and having made that choice it did not always exclude her from others. As McKinlay has pointed out “even when they have children, they may choose not to ‘conform’ to the behaviour usually associated with the social category ‘mother’; they are ‘independent’ individuals, as are their children”.² Accordingly she has suggested that resultant approaches to child-care reflected each mother’s opinions about motherhood. Mothering styles within this paradigm could therefore, mirror the ‘service’ paradigm in so far as they could be child-centred, or they could require that the child be fitted around a mother’s career or tertiary study. Fundamental to this paradigm were the rights of

¹ R. McKinlay, ‘Motherhood and self-definition in New Zealand’, p.228.

² R. McKinlay, p.229.

both the mother and the child to an ‘independent’ self.³ Clearly women began to explore this notion of an ‘independent’ self because more women were in paid employment in the 1970s compared with the previous decade. In 1977 Jane Ritchie replicated an earlier 1960s study that investigated child-rearing patterns in New Zealand. The 1977 study found that 35% of mothers worked either full or part time compared with 82% of mothers in the 1963 sample, who had not worked since they married.⁴

I have suggested in previous chapters that in the context of the hospital children’s ward professional staff tolerated resident mothers because they were deemed psychologically beneficial to their child. Professional practice appeared to support the view that motherhood was a totally child-centred way of being. I have also speculated that this view placed upon mothers an expected standard of ‘good’ mothering against which all mothers would be judged. The emergence of a paradigm of motherhood that asserted the rights of the mothers to their own independence would arguably have impacted on the way in which ‘family-centred care’ was enacted in the children’s ward. According to McKinlay, the style of mother-expert relationship in this paradigm appeared more fluid. She explained that it “depends on the individual mother and her past experience of experts – she may be in awe of doctors, or she may be herself a nurse, teacher (or doctor) with confidence in her own abilities”.⁵

Although parents now had far greater access to their hospitalised child than had been allowed in previous decades, professional practice remained child-centred rather than family-centred. Given the context of new ideas and attitudes towards mothering that emerged in New Zealand during the 1970s, it would be reasonable to suggest that the 1970s and 1980s should

³ R. McKinlay, p.229.

⁴ J. Ritchie, ‘Child rearing patterns: some comparisons’, *Psychology Research Series*, No. 2, University of Waikato, Hamilton New Zealand, 1979, p. 4.

⁵ R. McKinlay, p.229.

have been the watershed years for paediatric nursing practice in which the focus of care would shift from the 'child' to the 'family'. The emergence of 'motherhood as a life experience' suggested that earlier 'rule of thumb' approaches applied to all mothers and children when admitted to hospital would no longer be appropriate. As this new paradigm of motherhood emerged, so attitudes towards children began to change. As McKinlay noted, "ideologies based on this paradigm cannot avoid confronting the possible conflict between the needs of mothers and children".⁶

Changing attitudes towards children

The prevalent attitude towards children in 1970s New Zealand society has been characterised by McDonald as "the child as citizen".⁷ He has suggested that this change in attitude also saw a move away from the ideas of psychological knowledge and medical interference as the primary means by which children's behaviour could be adjusted. A social justice model emerged which emphasised that children made up a separate interest group that also had rights within society. Given this view, McDonald pointed out the inevitability that "there be a challenge to the traditional and legalistic view that children's best interests are synonymous with those of their parents".⁸ Attention was now drawn not only to 'women's rights' but also to 'children's rights'. However, where motherhood was concerned the possibility for conflict seemed apparent because in McKinlay's estimation "the rights of one can be seen to impinge on the rights of the other".⁹ For instance, as many within the women's movement were campaigning for increased availability and access to day-care for children, Parents Centres and other organisations spoke out against it. The view that any mother and child separation was potentially harmful was therefore, continually promoted. MacKinlay suggested that this new focus on 'children's rights'

⁶ R. McKinlay, p.229.

⁷ D. McDonald, 'Children and young persons in New Zealand society', in Koopman-Boyden, P.G. (ed.), *Families in New Zealand Society*, Methuen, Wellington, 1978, p. 51.

⁸ D. McDonald, p. 51.

⁹ R. McKinlay, p.231.

tended to advocate a 'service' notion of the mothering role. However, it also supported the involvement of the state in meeting the child's needs if the mother or family were unable to.¹⁰

The persistent 'expert'

The 'experts' advocated this 'service' notion of motherhood and arguably fuelled the 'women's rights' versus 'children's rights' debate. In 1974, James and Joyce Robertson, from the Tavistock Clinic London, came to New Zealand following an invitation from the New Zealand Parents Centres. Described in a *New Zealand Listener* article as "specialists in child-care",¹¹ they gave the principal reason for their visit as being to promote the significance of visiting for children in hospital. However, both were adamant that any situation that resulted in separation between mother and child was potentially detrimental to the child's emotional wellbeing. Expressing the 'service' ideology of motherhood, they stressed that "generally we want mothers to be with their children in all situations".¹² Other comments also suggested that the 'inexpert' parent was still reliant on the 'experts' to point out where they were going wrong. The Robertsons noted that "we often think parents put their children in day-care without knowing the damage they are probably doing".¹³

During their stay in New Zealand the Robertsons also participated in the seminar 'Children in Separation' organised by the Federation of New Zealand Parents Centres. Public pressure for change in the care of the hospitalised child had been mobilised and following this seminar the Working Party for Children in Separation was formed. They continued to lobby for better parental access to the hospitalised child. A meeting with the Minister of Health, Mr. R. Tizard, resulted in another Health

¹⁰ R. MacKinlay, p.231.

¹¹ S. Bowen, 'Desperate in hospital', *New Zealand Listener*, May 25, 1974, p. 13.

¹² S. Bowen, p. 13.

¹³ S. Bowen, p. 13.

Department Circular Letter which supported the Working Party aims and once again encouraged hospital boards to move towards implementing the aims outlined in the Platt Report. Specific mention was made of the need to provide living-in facilities for mothers of children under five and unrestricted visiting for children, and advocate for an increased awareness and understanding of the importance of preventing the separation of mother and child during hospitalisation.¹⁴ I would speculate, however, that the Parents Centres involvement in the lobby for more liberal parental access to the hospitalised child represented a small part of their much wider political agenda that opposed separation of mother and child in any situation. As part of a broader agenda it nonetheless provided the opportunity to promote, through their publication *Parents Centres Bulletin*, the ‘scientific’ reasons for avoiding mother-child separation. Articles written by the ‘experts’ appeared regularly and lent weight to what had been described as an increasingly polarised debate.¹⁵

In a 1971 article for the *Parents Centres Bulletin* Ruth McNeur, senior paediatric sister at Dunedin Hospital, discussed the problems of separation in hospital. McNeur’s comments pointed to the inherent paradox with regard to the separation thesis, when applied to the children’s ward. Her opening remarks reflected, on the one hand the persuasive discourse of the separation thesis and its exclusivity as the fundamental reason for change in the children’s ward.

We in New Zealand are rarely involved in the more catastrophic family separations caused by war, famine and national disasters, and so we are able to be concerned with more subtle forms which, though less obvious, are none the less damaging to children.¹⁶

¹⁴ *Circular Letter No. Hosp. 1974/166*, New Zealand Department of Health, Wellington, 1974.

¹⁵ S. Kedgley, *Mum’s the Word*, Random House New Zealand Ltd., Auckland, 1996, p. 262.

¹⁶ R. McNeur, ‘Young child in hospital’, *Parents Centres Bulletin*, November, 1971, p. 10.

On the other hand, an inherent paradox is revealed when these opening remarks were contextualised by McNeur's experience

Although most of us think of hospital admission, as separating wanted children from familiar adults, there is another small but growing group of children in our community. These are children admitted to hospital in which separation is a form of temporary rescue from an intolerable home situation.¹⁷

Locating McNeur's comments in their social and cultural context, it would appear that they expressed the emerging 'children's rights' view. McDonald described this prevalent attitude toward children in the 1970s as one that challenged previous beliefs that children's interests were synonymous with those of their parents.¹⁸

It seems unclear why nurses continued to support a maternal deprivation thesis despite its limitations in addressing the practical implications of care by parents in the children's ward. McNeur alluded to this dilemma when she pointed out that "we could simply say that having the parents present with the child in hospital would solve the problems of separation".¹⁹ She went on to highlight the complexity of familial relationships explaining that "first of all parents must *want* to be with the child...many parents *want* to be there but because of the needs of the rest of the family are unable to do so".²⁰ It would appear that the separation thesis constructed a 'naturalness' and 'universality' of behaviour applied to all families. McNeur's comments suggested an awareness of the arrogance of such a position.

The Report of the Select Committee on Women's Rights was published in June 1975. Some of the statements expressed in Chapter 6 of the Report

¹⁷ R. McNeur, p. 10.

¹⁸ D. McDonald, p. 50.

¹⁹ R. McNeur, p. 10.

²⁰ R. McNeur, p. 10.

dealt with the issue of child-care and seemed to express views that reflected the new paradigm, ‘motherhood as life experience’. The committee conceded that “for women to be able to exercise genuine choice in their own lives some of the responsibility for the care of young children must be borne by the wider community”.²¹ The committee hastened to point out, however, that they were not in favour of actively encouraging parents to place their children in day-care. Instead, they quoted from the Plunket Society submission and advanced the view that “the best environment for a child is the one-to-one basis of a mother or ‘mother-substitute’, which is loving, personal and continuous”.²² Although some of the rhetoric had changed to accommodate a new paradigm of motherhood, arguably the ‘experts’ still controlled the reality.

Some commentators in the 1970s attempted to draw public attention to the role that the ‘expert’ historically had had in New Zealand society. In a series of two articles published in the *New Zealand Listener*, New Zealand historian Erik Olssen examined the influence that Dr. Frederic Truby King, founder of the Plunket Society, had in shaping the national character. Olssen’s first article, entitled ‘Breeding for the Empire’, suggested to readers that the founding of the Plunket Society to improve the health of young New Zealanders was only the means by which Truby King could fulfill his more lofty goals. Creating a character structure that would preserve the ascendancy of the British culture and guide women into motherhood and domesticity was, Olssen said, “the *real* dynamic behind the society under Truby King’s leadership”.²³

Promoting the ideals of motherhood and domesticity were not new in themselves, as Olssen explained. Many religious families had, for some time, supported the training of young women in domestic science. What

²¹ *The Role of Women in New Zealand Society*, Report of the Select Committee on Women’s Rights, A.R. Shearer Government Printer, Wellington, 1975, p. 86.

²² *The Role of Women in New Zealand Society*, p. 86.

²³ E. Olssen, ‘Breeding for the empire’, *New Zealand Listener*, May 12, 1979, p. 18.

was new, Olssen argued, was the way in which the Plunket Society envisioned domesticity.

The religious had conceived of domesticity in purely moral terms, whereas Plunket baited the hook with the promise of improved standards of childcare. Middling families undoubtedly found the promise of better health for their children very attractive, and they already held science in high esteem. The new cult of motherhood offered dignity and high purpose to wives who did most of their own housework and cooking. Thanks to Plunket it also enabled mothers to achieve a scientific certainty about child rearing and reduce the risk of their babies dying.²⁴

Olssen's second article, entitled 'Producing the Passionless People', outlined the continued growth and influence of the Plunket Society. The declining infant mortality rate was persuasive evidence of Plunket's success. Olssen cited that almost 60% cent of men volunteering or conscripted for war duty did not meet the required standard of fitness and this bolstered Plunket's claim of "national debility".²⁵ It was crucial that every baby have the opportunity to develop into a strong and healthy adult. The government was persuaded that improved standards of mothering and advancing motherhood itself were the means by which this could be achieved.

Government support for Plunket's aims and objectives ensured that very few New Zealand families would escape the influence of 'experts' in their daily life. Olssen drew attention to the fact that the New Zealand government had commissioned the writing of Truby King's book *Baby's First Month*. Subsequently the Department of Health printed 30,000 copies and all mothers were issued with one within days of childbirth.²⁶

²⁴ E. Olssen, p. 19.

²⁵ E. Olssen, 'Producing the passionless people', *New Zealand Listener*, May 19, 1979, p. 20.

²⁶ E. Olssen, p. 20.

Although Olssen offered the New Zealand public a refreshingly new and critical analysis of role that the Plunket Society played in forming our collective national psyche, the Society remained the bastion of child health services in New Zealand. The Plunket Society received increased financial support from the government in 1971.²⁷ The *New Zealand Child and His Family*, written by Dr. Neil Begg, Director of Medical Services to the Plunket Society, replaced the Plunket manual, *Modern Mothercraft*, in 1970. The new manual represented, in Begg's estimation, a departure from earlier Plunket advice that gave "potted rules of treatment for all childhood problems".²⁸ Instead the focus had shifted from concerns of infant feeding and home hygiene to a broader view of child health which included "unhappiness, social maladjustment, juvenile delinquency and mental ill health".²⁹

Attention was now drawn to the importance of the child's environment if it was to grow into a psychologically stable adult. The home and the mother were considered central to achieving this. Although the 1970s saw the emergence of a new paradigm of motherhood, 'expert' rhetoric in the manual reflected the earlier 'service' ideology of motherhood. Begg did acknowledge the changing role of women in New Zealand society but he quickly followed this with a caveat to the modern mother.

Unless there is a clear need to earn money when the family is young— as there is in the case of some widows—the mother is better in her home. It is an empty place without her. A new refrigerator, a television set, a motorcar are not sufficient recompense to a young child for the absence of his mother...In all these changing circumstances there is need for reassessment of old-fashioned views of the woman's role. Yet despite these new aspects of life, sex and childbearing are biological facts too stubborn to be denied. The most

²⁷ *New Zealand Parliamentary Debates, August 24-September 21, 1971, Vol. 374, p. 3222.*

²⁸ N. Begg, *The New Zealand Child and his Family*, Whitcombe & Tombs Ltd., Christchurch, 1970, p. 12.

²⁹ N. Begg, p. 11.

important task a woman can have, even though it be both difficult and challenging is that of wife, homemaker and mother. Any other task is of less importance.³⁰

The influence of ‘experts’ and the authority they wielded was highlighted in other publications during the 1970s. Although I suggested in the previous chapter that the Women’s Movement had empowered women to question the areas of traditional male dominance in the public arena, a 1976 *Listener* article highlighted that the traditional hierarchy and ‘expert’ dominated hospital system were still alive and well. Wellington journalist, Judy Zavos, investigated the access that parents had to their hospitalised child. She spoke to parents and recorded their experience of hospitalisation and from their accounts concluded that “hospital boards and medical staff do not yet fully appreciate the emotional needs of small children”.³¹ Interestingly Zavos’s evidence also suggested that rather than pose any challenge to the traditional hierarchies within the hospital system, mothers found that collusion with these hierarchies served, in most cases, to be the only way to legitimise their requests to stay with their child. Zavos quoted one mother who told her that

although they say that mothers can live in, I found them reluctant to let us, in fact. When I asked the charge nurse she said she didn’t think I could although as far as I could see there was a bed available. It was only because I had a cousin on the medical staff that I got permission.³²

Similar situations had also been documented in a 1972 article for the *Parents Centres Bulletin*. Two mothers had written about having their child in hospital. Their accounts highlighted that unrestricted access to their children was not a given but was at the discretion of the ‘experts’, in most instances the doctor. Parents encountered further stress when faced

³⁰ N. Begg, pp. 20-21.

³¹ J. Zavos, ‘Hospital with or without mum’, *New Zealand Listener*, November 27, 1976, p. 21.

³² J. Zavos, p. 21.

with a situation where the ‘experts’ were in disagreement. Paddy’s mother explained:

My son Paddy was admitted to hospital for an operation on clubfeet when he was 21 months old. His doctor had written to the Superintendent of the hospital requesting that I be allowed to stay with Paddy for most of the day and so it was arranged....on arrival at the hospital I found that both the sister in charge of the ward, and the house surgeon, were opposed to letting parents visit their children outside the official visiting hours – 2.30 p.m. to 6.00 p.m. Both denied knowledge of my doctor’s letter, and the house surgeon doubted that such a letter existed.³³

Differing visiting policies between hospitals and in some cases between different wards in the same hospital also placed parents under undue stress. Fiona’s mother wrote of the difficulty she faced having to explain to her seven year old daughter that she was not allowed to visit her after her tonsillectomy, when only a few months earlier, having undergone eye surgery, she had spent most of the day with her. Fiona’s mother questioned the no visiting rule, writing to the Medical Superintendent. Her request to stay with Fiona was denied, although she was granted permission to visit for five minutes on the day of surgery. The Medical Superintendent’s reasons for the no visiting policy expressed the view that having parents present post-operatively could prove potentially harmful to their children. Fiona’s mother quoted the Medical Superintendent who wrote that “children had to be carefully watched after surgery and that visitors could interfere with post-operative nursing procedures”.³⁴

Although government rhetoric was urging hospital boards to begin implementing the aims described in the Platt Report, the public were left in no doubt that the ‘experts’, both medical and administrative, would have the final say. In July 1972 *The Press* published new hospital rules

³³ ‘Mothers write in about their children in hospital’, *Parents Centres Bulletin*, June 1972, p. 14.

³⁴ ‘Mothers write about their children in hospital’, p. 16.

governing the visiting of children. The new regulations were suggested by Professor F.T. Shannon, Professor of Paediatrics, and approved by the North Canterbury Hospital Board. The public were informed that

Daily visiting for parents only from 12.30 p.m. to 7 p.m. on weekdays and from 10 a.m. to 7 p.m. at weekends. If neither parent is able to visit, arrangements for a suitable alternative visitor should be made with the ward sister.³⁵

Professional rhetoric in the 1970s and 1980s

Similarly to the writing in the public domain, New Zealand nursing and medical publications continued to promote the 'service' ideology of motherhood and reliance on 'experts' when issues of child-care or the child in hospital were addressed. Professor A.E. Fieldhouse, Professor of Education at Victoria University of Wellington, penned an article for the *New Zealand Nursing Journal* in 1973, on mother-infant interaction and its subsequent research implications for infant care. In his opening remarks Fieldhouse suggested that it was a well-established fact that a person's subsequent development was affected for better or worse by the quality of their early life experience.³⁶ This naturally meant examining the quality of the mother-child interaction because as Fieldhouse pointed out "the mother is the principal if not exclusive provider of such care".³⁷

He noted the absence of 'expert' research in New Zealand concerning the amount of mother-infant interaction, and described, with some concern, the findings of an American study that indicated most mothers of ten month old babies were unsure about the value of interacting with their babies apart from providing good physical care. Unfortunately Fieldhouse did not elaborate or speculate on possible reasons for the

³⁵ 'Visiting of children - new hospital rules', *The Press*, July 27, 1971, p. 15.

³⁶ A.E. Fieldhouse, 'The quality of infant care', *New Zealand Nursing Journal*, August, 1973, p. 8.

³⁷ A.E. Fieldhouse, p. 8.

mothers' responses. Arguably, American mothers might have been influenced by the earlier child-rearing ideology of J.B. Watson, who, like Truby King, actively discouraged emotional interaction with the infant. Although I would not dispute the importance of early mother-child interaction, Fieldhouse's tone suggested that it behoved the 'expert' to guide mothers toward purposeful interaction with their infants.

Mothers need to be informed of the significance of the ways in which they normally interact with their infants – of physical contact, of vocalisation, of being active with their infants – so that they will not only interact in those ways but will do so purposefully.³⁸

Finally, the implications for infant care were addressed. Although Fieldhouse did not refer directly to the current situation regarding parental access to the children's ward, he did suggest that if interaction was important for infants being cared for in their own homes then perhaps it was even more essential for infants in hospital.

The continued need for parents to seek 'expert' advice in matters of child-care was outlined explicitly in a letter to the *New Zealand Medical Journal* in 1973. Responding to the news that the Minister of Social Welfare was to introduce a budget counselling service, a community health consultant instead suggested that counselling in the area of child rearing and child development, particularly the psychological aspects, was more urgently needed. The letter expressed an extreme view of the 'inexpert' parent who was either, by way of mental defect or ignorance, harmful to their child. The writer noted that

I see child mismanagement many times a day and apart from some obvious psychological deficiencies in some of the parents the basic cause is ignorance on the part of both the father and the mother on their roles as parents and their part in the psychological, social and physical development of their children.³⁹

³⁸ A.E. Fieldhouse, p. 11.

³⁹ C.A. Smith, 'Child rearing practices', *New Zealand Medical Journal*, May, 1973,

This letter elicited a response the following month from the Director of the Plunket Society. Begg was at pains to point out to the letter writer that Plunket nurses were already fulfilling the role of counsellor in matters of child rearing. He claimed that “about 96% of all mothers consult the Plunket nurse on matters of child development in this district”.⁴⁰ Begg also pointed out that “all trainees have instruction in budgeting, that they have instruction from medical specialists in paediatric matters, in social welfare from sociologists, and that the largest sector of their training is from university educational psychologists”.⁴¹ Implicit in this comment was the idea that ‘expert’ begets ‘expert’, and he drew attention to the existing ‘expert’ status of the Plunket nurse where issues of child-rearing were concerned.

The previous chapter indicated that medical commentary on the nature of nursing the sick child was commonplace in the 1960s, while nursing commentary was scarce. This had changed by the 1970s and the professional literature indicated that nurses were now discussing nursing issues arising in the hospital children’s ward. In November 1974, the *New Zealand Nursing Journal* printed an article from a talk given by Merian Litchfield, tutor at the Wellington School of Nursing. The article examined the various ways children could be cared for and the responsibility of the nurse in each of these.

Litchfield began by outlining the main conclusions that arose from John Bowlby’s work on maternal deprivation. She conceded that although the mother was traditionally the object of the child’s attachment, other individuals such as fathers, siblings, foster-parents or grandparents might substitute. However, for the purposes of this article she continued to refer to the mother as the primary caretaker in part because that was most

p. 344.

⁴⁰ N. Begg, ‘Child counsellors’, *New Zealand Medical Journal*, June, 1973, p. 411.

⁴¹ N. Begg, p. 411.

commonly encountered.⁴² She went on to describe the devastating effects for both the mother and child if it were admitted unaccompanied to the hospital. For the child the combination of the disease process itself and the emotional distress separation caused could well, in Litchfield's estimation, "affect the whole psycho-social development of the child".⁴³ Reflective of the 'service' style of mothering, Litchfield wrote in terms of the child's 'needs' and the mother's 'needs' as though they would be synonymous. Based on this premise she concluded that

not only is the child under intense stress, but also the mother. She has to cope with the anxiety over the illness of her child and its prognosis as well as the separation in which she is unable to fulfil her maternal role.⁴⁴

Asking readers to keep her preceding comments in mind, Litchfield went on to discuss the ways in which children could be best cared for and the nurse's role in each. She examined home nursing, mother resident with the child in hospital, the child in hospital with parents visiting, and the child in hospital without parents visiting. For the purposes of this study I have limited my analysis of Litchfield's comments to those made about the resident mother. Litchfield began her discussion of resident mothers by drawing reader's attention to the 1959 Platt Report recommendation that mothers of children under five years of age be enabled to stay with them, thereby avoiding the risks of mental ill health associated with separation. She then outlined the advantages, both to the mother and the nurse, of having the mother stay in hospital with her child. Again reasons for having the mother present were focused on the 'needs' of the child and of gaining the full benefit of having the mother living in.

She sleeps in a room with him; or at least does not leave him until he is sleeping. Then should he wake in the night, she should be called to

⁴² M. Litchfield, 'The paediatric nurse – and a child in hospital', *New Zealand Nursing Journal*, November 1974, p. 17.

⁴³ M. Litchfield, p. 17.

⁴⁴ M. Litchfield, p. 17.

him. She is encouraged to feed and bath her own child, keep him entertained and put him to bed and get him up.⁴⁵

By carrying out this predetermined role the mother was protecting her child's emotional development and Litchfield considered that the mother would be "rewarded by a sense of satisfaction at being able to demonstrate her strong maternal impulse to love and protect her child".⁴⁶ This description of the resident mothers, similar to that in the 1960s, still relied on 'expert' justification for their presence in the children's ward. As a result the implicit standard of 'good' mothering, against which all mothers would be judged, continued.

The advantages to the nurse were considered to be two-fold. Firstly, time taken up with minor tasks would be saved. Secondly, the nurse would no longer have to spend time and energy dealing with emotionally distraught children and anxious parents. Despite these obvious advantages for all parties, Litchfield was concerned at the number of parents who were still unaware of the effects of separation and did not ask to live-in. Litchfield elaborated further on the nurse's role when the mother was resident and did acknowledge that "she becomes supportive to the mother and supplements the mother's care of the child where necessary".⁴⁷

In the context of the hospital ward Litchfield explained that resident mothers would be unsure of themselves and might exhibit behaviour changes. She advised nurses that "she may appear demanding; or child-like in the presence of authority figures, the nurses and doctors, who will judge her skill in handling her child".⁴⁸ She therefore, concluded that "the nurse must also care for the mother and without dominating her. To care for the mother and child as a unit solves many of the problems".⁴⁹ I would

⁴⁵ M. Litchfield, p. 18.

⁴⁶ M. Litchfield, p. 18.

⁴⁷ M. Litchfield, p. 18.

⁴⁸ M. Litchfield, p. 18.

⁴⁹ M. Litchfield, p. 18.

argue that these comments expressed a professionally-centred view of family-centred care that did not consider the resident mother an equal partner with professional staff in the care of her child.

The following year McNeur contributed an article to the same journal. At the time McNeur was paediatric ward sister in Dunedin hospital. Her opening remarks described the process of change, in particular attitudinal change, which she considered by necessity took the longest. Witnessing the change in attitude toward parents in the children's ward was the change that she had been most closely involved in. She recalled the attitudes of her student nursing days where parents were viewed as "disturbers of children and ward routine, who were allowed to visit for an hour on three days a week".⁵⁰ Her following comment implied that the maternal deprivation thesis was the reason why attitudes had changed and "most people concerned with the care of children appreciate the effect of separation of the young child from his parents and family".⁵¹

Revealed as a pragmatist, McNeur conceded there was still a gap between policy and practice where resident parents were concerned. Medical objection, ignorance among nursing staff and lack of facilities were all suggested as reasons for this. Similarly, to the situation described by Litchfield, McNeur also noted that when parents were resident it was the mother who usually fulfilled this role. She went on to point out that not all parents wanted to stay with their child, nor was it easy for some parents because of other family commitments. McNeur also suggested that resident parents were not always acting as they would normally, although her comments indicated a level of understanding that was not apparent in Litchfield's article.

Quite often one recognises that it is the parents who need as much as, if not more care and support than, their child. If parents are being

⁵⁰ R. McNeur, 'Parents in the paediatric ward', *New Zealand Nursing Journal*, November 1975, p. 20.

⁵¹ R. McNeur, p. 20.

awkward and difficult they usually have good reason and it is worthwhile getting to know them and making them feel accepted.⁵²

She went on to discuss the other advantages of having resident parents although she referred again to lessening the pain of separation as the most important reason. McNeur considered that when parents were involved in the day to day care of their child they had a better understanding of what was being done. She believed that nurses were grateful for parental help with tasks such as feeding and bathing, which left them more time for specialised treatments. She concluded that this did not mean, however, that nurses were relinquishing the care of the child to the mother but instead they would “adapt their role to that of ‘parent helper’”.⁵³ From McNeur’s comments I would suggest they demonstrated an acute awareness that family-centred care *was* nursing care and as such the traditional nurse-child dyad would be irrecoverably altered. As a champion for this change, she realised that continuing support for it lay in the rhetoric of the separation thesis, despite its inadequacies as a theory on which to base and articulate a radically different model of nursing care.

In 1977 the *New Zealand Nursing Journal* published an article that reported on the activities of the Working Party for Children in Separation since its formation following the visit of James and Joyce Robertson in 1974. The article outlined the issues of mother-child separation in infancy, raised as a result of the seminar with the Robertsons. It noted that “many people attending the seminar expressed the need for action to reduce the amount of mental ill health and emotional disturbance which at present is responsible for much unhappiness, delinquency and socially disruptive behaviour”.⁵⁴

⁵² R. McNeur, p. 20.

⁵³ R. McNeur, p. 21.

⁵⁴ ‘Children in separation’, *New Zealand Nursing Journal*, February 1977, p. 15.

In its first year, the hospital care of young children had been the Working Party's primary area of concern. By way of various presentations and representations to the Minister of Health it was pointed out that the Working Party had met with considerable success in highlighting the importance of avoiding separation of the parent and child during hospitalisation. The article quoted that

the Working Party has been very encouraged to hear from all over the country that parents are now finding that, by and large, hospitals are becoming more aware of the need of parents to be with their young children during a hospital stay.⁵⁵

Included in the article were excerpts from letters received from parents indicating that the attitude of hospital staff towards parents had mellowed. It is interesting to note, however, that in some instances parent involvement was still mediated through medical staff. One parent noted that "we are very fortunate at the Thames Hospital to have a sympathetic Superintendent towards parent-child relationships".⁵⁶ Another letter illustrated a paradoxical situation with regard to policy and practice, observing that "while visiting hours in the children's wards remain technically rigid, interested parents find they are welcome at any time and are encouraged to assist with non-medical procedures".⁵⁷

Although the Working Party felt they had made considerable in-roads convincing hospitals of the need for parents to be with their child during a hospital stay, it was apparent that other professionals did not necessarily share this view. The writer of a 1979 article in the *New Zealand Medical Journal*, Dianne Green, a junior lecturer in psychology, questioned the importance of parental presence in the children's ward considering that "when Bowlby and others pointed out the dangers of separation of mother and child and particularly in hospitalisation, a general dismay led to over-

⁵⁵ 'Children in separation', p. 15.

⁵⁶ 'Children in separation', p. 15.

⁵⁷ 'Children in separation', p. 15.

reaction”.⁵⁸ Citing psychiatrist Michael Rutter as a source, she noted that “these views have been shown to be too sweeping”.⁵⁹ Her point implied that Bowlby’s theory of maternal deprivation had been applied indiscriminately and its application in the context of the children’s ward was questionable.

She went on-to to suggest:

Hospitalisation is to be avoided as far as possible between the ages of six months and four years, but in all cases, the kind of care given in hospital will be critical. This should include enough toys and play, good physical conditions and affectionately skilful handling by as few nurses as possible, so that substitute attachments may be formed and security built up.⁶⁰

Questioning the relevance of Bowlby’s theory in the context of the children’s ward in the late 1970s was long overdue. Green’s discussion, however, appeared to overlook the fact that acceptance of parental presence in the children’s ward had hinged on this theory. In debunking Bowlby’s theory without offering an alternative framework that would accept parental presence as a right, implied, at worst, a return to parental exclusion.

The influence of attachment theory, however, remained pervasive and as Kedgley has noted the notion of bonding was redefined during the 1980s. She explained that “it [bonding] was used to describe not just the relationship between the mother and baby immediately after birth, but the mother-child relationship that developed in the first year of life”.⁶¹ These ideas were not that different from Bowlby’s theory of maternal deprivation. She cited New Zealand psychiatrist Dr. Peter McGeorge who expressed the

⁵⁸ D. Green, ‘The hospitalisation of children’, *New Zealand Medical Journal*, May 9, 1979, p. 352.

⁵⁹ D. Green, p. 352

⁶⁰ D. Green, p. 352.

⁶¹ S. Kedgley, *Mum’s the Word*, Random House New Zealand Ltd. Auckland, 1996, p. 290.

view that “bonding is critical in a baby’s first year of life, and that infant attachment during this time is predictive of behaviour in later life”.⁶² As I have indicated in earlier chapters, during the 1960s and 1970s the view that any mother-child separation was potentially harmful for the child’s later psychological adjustment ran in ideological opposition to the debate surrounding the provision and access to day care for children. Although supposedly ‘new’ bonding theories were promoted in the 1980s, women’s participation in the workforce rose sharply in the early 1980s, from 38.6% in 1981 to 45.2% in 1986. Statistics New Zealand noted that “by 1986, 2 in 5 women whose youngest child was aged one to four years, and 1 in 4 women with babies under one year were in the paid labour force”.⁶³ Government attitude towards the childcare debate had changed considerably from previous decades and in 1984 the incoming Labour government was, as McDonald pointed out, “committed to reforms which would provide early childhood services of high quality and contribute to equity for women in the workforce and in public life”.⁶⁴

These education reforms continued into the fourth Labour Government’s second term in office. Prime Minister David Lange had taken over the Education portfolio and almost immediately appointed a succession of working parties on universities, schools and early childhood care. Dr. Anne Meade, social policy advisor to the Prime Minister, was the convenor of the Working Group, charged with examining provisions for early childhood education. The committee’s findings were reported in 1988 and proved to be the catalyst for a significant change in government policy concerning childcare. The contents of the report articulated the prevailing paradigm ‘motherhood as life experience’, by pointing out that “women should have the right of choice and control over their own lives”.⁶⁵ Meade

⁶² S. Kedgley, p. 291.

⁶³ *All About Women in New Zealand*, Statistics New Zealand, Wellington, 1993, p. 89.

⁶⁴ G. McDonald, ‘Organisations concerned with early childhood care and education’, in Else, A. ed., *Women Together*, Daphne Brasell Associates Press, Wellington, 1993, p. 336.

⁶⁵ *Education to Be More: Report of the Early Childhood Care and Education Working Group*, Government Printer Wellington, 1988, p. 40.

had denounced Bowlby's maternal deprivation theory suggesting it was tantamount to a myth that it was harmful for a child to be separated from its mother. She was critical of the government's whole-hearted acceptance of this theory and the subsequent influence it had exerted on childcare policies over the previous three decades. Similar to the views expressed by Jessie Bernard and Margaret Mead in the 1970s, Meade pointed out that

the idea that pre-schoolers should spend all their waking hours in the company of their mother was unique to the child-rearing theories that gained prominence after the Second World War. Historically and cross-culturally, young children have been reared in an extended family or small social group, by a variety of adult mother- and father-substitutes.⁶⁶

The government accepted the arguments put forward in the Meade Report. McDonald noted that the government's response, 'Before Five', recommended a funding increase of 125% over four years to equalise funding between the different services by 1994/5, additional subsidies for children under two, and improved minimum regulations for buildings, staffing ratios and qualification".⁶⁷ Implementation of the policies and recommendations began in 1989. However, the Labour government did not retain power in 1991 and the proposed childcare reforms suffered as a result. During the 1980s, however, government and educational 'experts' were beginning to question the relevance of Bowlby's maternal deprivation theory in the context of women's lives and had begun to implement policy that reflected a new direction. In contrast medical 'experts' continued to rely on such theory as the fundamental reason for parental presence in the children's ward.

In 1980 researchers from the Dunedin Multidisciplinary Child Development Study reported that previous studies published by both

⁶⁶ *Education to Be More*, p. 11.

⁶⁷ G. McDonald, pp. 336-337.

Douglas in 1975 and Rutter in 1976 had indicated that, given certain circumstances, the negative effects of hospitalisation could be long term. It was noted, however, that the children in the studies were born some years prior to changes in paediatric practice and these changes might have improved the short and long-term consequences of hospitalisation.⁶⁸ Given this information, a long-term prospective study of the development and behaviour of the children in the Dunedin Child Development Study, who had experienced hospital admission during their pre-school years, was initiated. This indicated that behaviour changes were not reported in the majority of admissions. However, the highest incidence of reported behaviour deterioration was revealed in children aged between thirteen and thirty-six months. The researchers concluded that these findings were in accordance with Bowlby's attachment theory and suggested that "all should be aware of this and do everything possible to reduce these effects by extended parent contact".⁶⁹

From a scientific viewpoint such conclusions appeared reasonable and valid. The young child's increased vulnerability to the negative effects of hospitalisation was the 'problem' and increased parental presence was the 'solution'. However, I would argue that the continued reliance on 'rule of thumb' approaches constructed a 'naturalness' and 'universality' of behaviour assumed to be applicable to all families. These approaches were in direct contrast to a societal attitudinal shift that took place in the 1980s in regard to day care for children and its potentially harmful effects of separating mother and child. Indeed even some medical 'experts' conceded that there were more opinions than facts driving the day care debate. Reflecting on the influence of John Bowlby's separation theory

⁶⁸ B. Simons, J. Bradshaw & P.A. Silva, 'Hospital admissions during the first five years of life: a report from the Dunedin Multidisciplinary Child Development Study', *New Zealand Medical Journal*, February 1980, p. 144. The Dunedin Multidisciplinary Child Development Study traces a cohort of children born in 1968 and covers a wide range of developmental, health and lifestyle issues.

⁶⁹ B. Simons, J. Bradshaw & P.A. Silva, p. 147.

with regard to day care, Dr David Geddis, Medical Director to the Plunket Society, wrote:

Furthermore, not only were the circumstances of the children studied radically different from the situation of many of those utilising day nurseries but the conclusion that it was the separation per se which was the causal factor accounting for the child's poor development now appears erroneous.⁷⁰

If the relevance of Bowlby's theory in the context of day care was now open to challenge, it begged the question as to why, in the context of the children's ward, its relevance remained largely unchallenged. This is not to imply, as Green did, that questioning the relevance of Bowlby's theory in the context of the children's ward might in some way support a return to the days of parental exclusion. Rather it reveals another paradox of the separation thesis in the context of the hospital children's ward. On the one hand it had provided the 'scientific' justification for allowing mothers to be resident with their young children. On the other, it was used as a theoretical gatekeeper lest all parents should assume they had a 'right' to live-in with their child regardless of age.

Evidence of this paradox was found in the Christchurch Hospital children's wards in 1984. A number of parents, who believed that any parent as of 'right' should be able to live-in with their child, had formed the 'Young Patients Rights Group'. They had drawn considerable media attention to the lack of facilities for live-in parents and the hospital's 'eligibility' criteria that determined which parents would be allowed to live-in. A somewhat defensive response was issued to the media from the Health Services Committee of the North Canterbury Hospital Board claiming that "parents not eligible to "live-in" with sick children at Christchurch Hospital could not expect to use the hospital as a motel".⁷¹ It appeared from the Board's point of view that the boundary between open visiting

⁷⁰ D. Geddis, 'Day care, working mothers and the pre-school child', *New Zealand Medical Journal*, September 1980, p. 202.

⁷¹ 'Hospital cannot be used as a motel', *The Press*, August 9 1984, p. 2.

and living-in had become blurred and a distinction had to be made between the two. The article reported that the Board had decided that the open visiting policy for parents would remain unchanged. Parents, however, would no longer be permitted to sleep on the floor next to their child and “beds would not be provided for parents who did not meet the living-in criteria”.⁷² The Medical Superintendent-in-Chief Dr. Ross Fairgray, noted that “priority was given to breast feeding mothers, parents of pre-school children and seriously ill children”.⁷³

Endorsing the sentiments expressed by the Hospital Board, the following morning’s editorial pointed out that the “convenience of patients’ relatives”,⁷⁴ could not take precedence over the welfare of patients. Parents were categorised as being either harmful or helpful to their hospitalised child. Assignment to one or other of these categories was clearly a medical decision. The editorial explained that

the concerned attention of parents may interfere with treatment and even upset recovery. In other instances, their presence may be reassuring and helpful. How closely parents should be permitted to attend a child in hospital has to be a medical decision, based on what appears to the medical staff to be in the child’s best interests.⁷⁵

The editorial outlined, as the Board had done, those parents that would be eligible to live-in and reiterated that “living-in with a sick child still has to remain a matter for consideration and judgement, not a right open to all who may demand it”.⁷⁶

These comments expressed a position whereby parental presence in the children’s ward appeared to be tolerated but not actively encouraged. Parental presence did not equate to parental partnership in care because

⁷² ‘Hospital cannot be used as a motel’, p. 2.

⁷³ ‘Hospital cannot be used as a motel’, p. 2.

⁷⁴ ‘Children in hospital’, *The Press*, August 10 1984, p. 10.

⁷⁵ ‘Children in hospital’, p. 10.

⁷⁶ ‘Children in hospital’, p. 10.

‘knowledge’ of what was in the child’s best interests was defined and validated by the ‘experts’.

Although the literature has shown that government policy in the 1970s supported and encouraged hospitals to provide living-in facilities for mothers of children under five, commentators in the 1980s noted that the course of change in conditions for hospitalised children had been slow. These changes were characterised by what could only be described as reactive responses. For instance, the National Children’s Health Research Foundation had funded an enquiry into the care of children in New Zealand hospitals. The report culminating from this enquiry into twenty-three hospitals admitting children was published in 1982. Commenting on the enactment of change in conditions for children in hospital, principal researcher Robin McKinlay explained that

public pressure leads to Department of Health recommendations to hospital boards, and innovations follow according to the priorities of the hospital boards concerned. Unfortunately, where these innovations make demands on board funding, it is clear in many cases that they are not given high priority.⁷⁷

While such changes might have been supported in principle, parents did not always find that they were reflected in practice. This was often due in part to the physical constraints of particular hospitals. As the report pointed out, “the actual accommodation they are able to offer is in many cases make-shift, crowded and sub-standard, or on a “user-pays” basis at a nearby staff residence”.⁷⁸ Coupled with bureaucratic restrictions on whether parents were ‘eligible’ to stay, able to get a meal, or make a hot drink, created tension and misunderstandings between parents and staff.

The report also highlighted that the status of parents in the children’s ward remained poorly defined. Similar to the sociological perspective of the

⁷⁷ R. McKinlay, *The Care of Children in New Zealand Hospitals*, National Children’s Health Research Council, Auckland, 1982, p. 22.

⁷⁸ R. McKinlay, p. 137.

'Swansea studies' the report focused on the 'roles' of professionals and parents. It pointed out that within the traditional hospital structure there was no 'role' for the parent to play. As a result staff expressed varying and often contradictory attitudes to the role parents, who were usually mothers, would undertake in the ward. Role confusion was considered more pronounced between mothers and nursing staff. Because mothers were not in hospital due to their own ill health, staff tended to classify mothers as 'carers' and it was presumed that mothers would continue to provide 'care' for their child while in hospital. After analysing statements doctors and nurses had made about mothers during the research, McKinlay posited that there were four implicit 'care-giver' categories to which mothers were assigned, dependent on the professional's opinions about what was appropriate for resident mothers to do in the ward.⁷⁹ The four 'care-giver' categories were mother as lay carer, mother as assistant carer, mother as inexpert carer and mother as expert resource.

'Mother as lay carer' assumed that the mother would continue with the usual tasks of child care undertaken in the home, feeding, bathing and playing. Mothers in this category were not encouraged by staff to be present when their child was undergoing a treatment or procedure; rather their role was one of comforter afterwards. In this category there was a clear boundary drawn between 'expert' and 'inexpert' care.⁸⁰ 'Mother as assistant carer' extended the mother's role whereby she was involved in the nursing care of her child under the supervision of the nurse. Nurses who considered mothers to be in this category would ask them to be present during treatments and might teach them how to observe their child following an operation or maintain their child's fluid balance record.⁸¹ 'Mother as inexpert carer' insinuated that some mothers were so incompetent that residing in hospital was viewed as essential in order for

⁷⁹ R. McKinlay, p. 138.

⁸⁰ R. McKinlay, p. 138.

⁸¹ R. McKinlay, p. 138.

them to be taught improved methods of child-care.⁸² ‘Mother as expert resource’ was, as McKinlay noted, a category in direct contrast to the other three.

We found some nurses and also paediatricians who looked on the mother in the ward as a learning resource for student nurses, and an expert on the care and condition of her own child, who should be consulted and involved in discussions of the child’s management.⁸³

The report did however, reiterate that changes in the organisation of paediatric care since the 1960s had called for an increasingly specialised response from paediatric nurses. Of interest, though, were the responses of principal nurses when questioned as to what experience and qualifications they considered advantageous for the appointment of a paediatric charge nurse. Some placed value on qualifications and experience, while others felt that a ‘motherly personality’ was more important than qualifications, which could be acquired on the job. These officers felt that motherhood could be a relevant experience for a children’s nurse’.⁸⁴

The different style of nursing required in the children’s ward was also emphasised in a 1983 nursing text entitled *Current Issues in Paediatrics: A Guide for New Zealand Nurses*. In the first chapter of this book Marion Griffin, paediatric nursing tutor at Christchurch Polytechnic, discussed the various challenges that were facing paediatric nurses in the 1980s. In her opening remarks she discerned that “the emerging concept of the paediatric nurse regards the child and his or her family milieu as the focus for practice”.⁸⁵ This statement suggested a shift in thinking about the style of nursing needed in the children’s ward. Earlier literature, both nursing and medical, had viewed the child as the focus and concern with the family was

⁸² R. McKinlay, p. 138.

⁸³ R. McKinlay, p. 138.

⁸⁴ R. McKinlay, p. 91.

⁸⁵ M. Griffin, ‘Paediatric nursing in New Zealand’, in K.P. Dawson ed., *Current Issues in Paediatrics: A Guide for New Zealand Nurses*, Butterworths, Wellington, 1983, p. 1.

limited to how family structure and relationships affected the family's ability to care for the child. In contrast, Griffin suggested that both the child and family should become the focus for the paediatric nurse. In advancing this new view of paediatric nursing practice, it was not pointed out, however, that nurses would need to recognise the power relations that existed between themselves and parents and that, arguably, a greater degree of mutuality would be required if successful nurse-family relationships were to develop. Similarly to McKinlay, Griffin considered that role confusion was the primary reason for antagonism between nurses and resident parents. She also pointed out that "clinical efficiency and effective patient care are not mutually exclusive".⁸⁶

This aptly described the contradictions of paediatric nursing practice in the hospital milieu and was illustrated in two texts in 1981 and 1984. Fifth year medical students carried out a survey in Christchurch during March and April 1981. The aim of the survey was to determine the amount of parental participation in the paediatric ward and to uncover barriers that affected parent's involvement. The sample of ninety-five children from the paediatric surgical ward at Christchurch hospital was composed of fifty-eight males and thirty-seven females between the ages of two years and thirteen years. The survey was administered within a maximum period of a month following discharge. Similar themes emerged in comments from parents related to nurses' attitudes. These included being overly efficient and too conscious of the routine.⁸⁷ A 1984 article in the *New Zealand Nursing Journal* suggested there was a continued belief amongst many nurses that the presence of parents was disturbing to the child and had the potential to disrupt the efficient management of the ward.⁸⁸

⁸⁶ M. Griffin, p. 6.

⁸⁷ P. Hale, D. Hutchinson, P. Speary, G. Spence, T. Sprott, 'Parental visiting in ward 23: A study of the factors relating to parental visiting in a paediatric ward at Christchurch Hospital', Community Medicine Projects, Department of Preventative and Community Medicine, Christchurch Clinical School of Medicine, 1981.

⁸⁸ V. Casey and S. Whiley, 'A challenge to nursing from the Child Health Report', *The New Zealand Nursing Journal*, August 1984, p. 22.

I would suggest that such views illustrated that, in the context of the traditional hospital structure, the presence of parents in the children's ward often placed nurses in challenging and contradictory positions. I would explain the contradiction as 'clinical expediency' versus 'mutuality.' Hospital structure and hospital policy still assumed that medical and organisational routines would take priority over the individual needs of children and their families. This professionally centred view of care assumed and accepted the imbalance of power between professionals and parents in the children's ward. In contrast, 'family-centred care' demanded mutuality between parents and professionals that arguably would disrupt the traditional ward routine.

Summary of 1970s and 1980s public and professional rhetoric

Nursing, medical and related literature pointed to a contradiction between much of the 'expert' rhetoric and the prevailing context of ideas and beliefs about motherhood and childhood during the 1970s and 1980s. Those within the women's movement expressed the new paradigm of 'motherhood as life experience' as they lobbied for increased day-care for children and attempted to quash the lingering myth of maternal deprivation. Similarly, attitudes towards children were also shifting. The concept of children's 'rights' challenged earlier ideas that considered psychological knowledge and medical intervention to be the primary way of ensuring children would develop into emotionally sound adults. Although aspects of government policy in the 1980s reflected these changing societal attitudes, medical 'experts' remained wedded to psychological theories and the 'service' style of motherhood.

In the context of the children's ward the influence and pervasiveness of these ideas remained apparent and were the fundamental reason that parental presence was tolerated with young children. As parents began to expect and demand the 'right' to live-in with their sick child *regardless* of age Bowlby's theory no longer seemed relevant. Nor did parents expect an 'expert' or scientific basis to legitimise extended presence as they expected

this, regardless of their child's age, and demanded it as a parental right. However, the majority of nursing and medical texts concerned with the care of children in hospital continued to prescribe the tenets of the separation thesis as the criteria by which it was determined whether or not a parent would be eligible to live-in with their child.

There is some evidence to suggest that during the 1980s nursing and related discourses began to advance a new view of paediatric care in the hospital whereby both the child and the family would become the focus of care. Accordingly, it was recognised that a new style of nursing would be required. However, commentary was mute on how this would be articulated and supported within the traditional hospital structure. The effects of these views on parents will be considered in the next section.

Parental reality

This section describes aspects of one mother's living-in experience during the 1980s. Jenny's story revealed that three significant factors shaped her reality: living-in (once regarded as an exception and now an expectation), negotiating boundaries and hospital assumptions of family. This experience is considered in conjunction with the ideas put forward in the professional and related literature during this time.

Ever since her son's birth Jenny realised that the congenital abnormality affecting her son, David meant he would require extensive surgery and lengthy hospital stays. David was eight months old when he experienced his first admission to the children's ward. This admission did not come as a surprise to Jenny; in fact she had been 'hoping' for it. She explained that "the first time he [David] was admitted I mean I was at my wits end by then because his skin, it was like third degree burns...I guess I was just glad to get to hospital for people to know what they were doing".⁸⁹ Jenny had not heard of Bowlby's maternal deprivation theory nor had she been aware of the various campaigns that had lobbied for freer parental access to

⁸⁹ Oral history interview with Jenny 4 September, 2001.

the children's ward. However, she recalled 'taking it for granted' that she would be able to live-in with David during his first hospitalisation in the early 1980s. If living-in with a child was assumed as a certainty, this arguably reflected a new view of the hospital as informal and flexible, a considerable change from the formal and rule bound institution of the 1960s.

The literature has indicated that hospital staff attitudes towards parental presence had mellowed during the 1970s and 1980s. Jenny noted "certainly you could tell as the months went on they [staff] were letting far more parents stay and providing rooms to do so".⁹⁰ Jenny felt that the provision of physical facilities, for example a bed to sleep on, was tangible evidence that parental presence was accepted. I asked her what factors might have influenced this increased awareness of the need for parents to stay with their child. She told me that "I think that on reflection it may have been coming from the nurses they were seeing more of a need and perhaps other parents as well".⁹¹ The literature has both supported and questioned the view that cast parents as 'agitators for change'. Parental agitation for change on the one hand, had met with some success, particularly at a political level, through the activities of the lobby group 'Children in Separation'. On the other hand, 'agitation' at the grass roots level was less successful and in most instances medical and administrative 'experts' still had the final say.

Collaboration versus conflict

I have suggested that nurses found that parental presence often placed them in contradictory positions. Jenny's account revealed that the same was true for parents. I have described the contradiction for the parent as 'collaboration versus conflict.' Jenny clearly remembered that there were varying attitudes among nursing staff toward live-in parents. "I found the

⁹⁰ Oral history interview with Jenny 4 September, 2001.

⁹¹ Oral history interview with Jenny 4 September, 2001.

first charge nurse was very old fashioned, very traditional. She wasn't giving as much as some of the younger nurses coming into the ward. It was sometimes very difficult."⁹² Jenny's account reflected a position where at times she was both supported and thwarted in her efforts to become involved in David's hospital care.

Other senior members of the hospital nursing staff also added to the conflict that living-in often presented for parents. As part of the hospital's administrative staff, senior nursing supervisors were not directly involved in the day to day life of the children's ward. However, they were responsible for ensuring that all wards were maintaining generic organisational standards. This was often a source of conflict for the live-in parent and Jenny vividly remembered an incident that illustrated this.

One night I was sitting in one of the children's big rooms with the television on after nine o'clock just trying to wind down. I'd had a big day with David and one of the night supervisors came round and turned the television off while I was sitting there and told me to go to my room, it [my behaviour] was unacceptable.⁹³

Jenny's account revealed considerable confusion as to the status of live-in parents. The literature has referred to confusion among paediatric staff regarding the resident parent's status, although it suggested that parents were usually classed as another carer. Jenny's encounter with the nursing supervisor indicated, however, that blurring the boundaries between professional and non-professional carers was a feature probably peculiar to the children's ward. Visiting hours were still utilised as the boundary between the hospital and the outside world. These were discrete periods of time, legitimised by the formal hospital structure, when 'people' who were not 'patients' or 'professionals' would be allowed access. I would argue that visiting also assumed a particular 'behaviour' on the part of the 'visitor'. Jenny's experience has suggested that these assumptions were reflected in the response to live-in parents.

⁹² Oral history interview with Jenny 4 September, 2001.

⁹³ Oral history interview with Jenny 4 September, 2001.

The literature has shown that the presence of live-in parents was accepted by the formal hospital structure because it met the needs of the child 'patient'. This view reflected the earlier 'motherhood as service' paradigm where mothers were personified as "servicing the needs of their children".⁹⁴ Clearly the nursing supervisor's response to finding Jenny relaxing as she would at home, indicated that 'behaviour' that was not concerned with meeting the needs of her child was deemed unacceptable. As far as Jenny was concerned, relaxing in front of the television at the end of the day would simply have been a way of meeting her own needs. However, in the context of the broader hospital structure, this seemingly benign act explicitly challenged the boundary between hospital and home. Interestingly, the conflict that the boundary between hospital and home presented continued, as Jenny remembered, until David was old enough to be admitted to the children's surgical ward. She told me that "the most comfortable we felt was in the older ward after David was three. That's when I felt most at home...you know I'd often go and have a coffee up with them [staff] at night and talk and they [staff] would talk to you like you were a human being".⁹⁵

'Expert' professional - 'inexpert' parent: Blurring the boundaries

Jenny's comment indicated that the boundary between the 'inexpert' parent and 'expert' professional was less obvious during the 1980s. The new paradigm 'motherhood as life experience' had emerged and contextual literature has suggested that the style of mother-expert relationship was now largely dependent on the mother and her prior experiences of experts. Due to David's medical condition, 'experts' had become a part of Jenny's life. However, the 'expert' was not held in awe. Instead the experience Jenny recalled of the Plunket nurse's first visit to David, revealed that she

⁹⁴ R. McKinlay, 'Motherhood and self-definition in New Zealand', Ph.D. thesis, Victoria University of Wellington, 1983, p. 137.

⁹⁵ Oral history interview with Jenny, 4 September, 2001.

was clear about what it was she needed from the ‘expert’ and pragmatic when it was not forthcoming.

The first Plunket nurse that came to visit David went ‘oh my God, oh he’s so pale what have you done to him?’ Well that was that, I never saw her again and that was my choice. You know I was at home with a new baby with a hole in his stomach...I needed reassuring.⁹⁶

Although Jenny was relieved to finally have David admitted to the hospital it did not alter the style of her relationships with the ‘experts’. Usually in an effort to achieve what she believed to be in the best interests of her son, Jenny remembered that “probably I pushed it sometimes too. I mean I had a few run-ins with both Charge Nurses”.⁹⁷ It was interesting that although medical staff played a huge role in David’s hospital care, when I asked Jenny about their attitudes towards her as a live-in parent she commented that “they didn’t really enter into it...I mean you hardly saw them basically”.⁹⁸

Who were the recipients of care in ‘family-centred care’?

Jenny remembered the nurses encouraging her to become involved in David’s care. However, the extent to which this reflected a collaborative relationship between parents and professionals remained questionable given that Jenny qualified it by telling me, “at that stage they were starting to get busier in the wards and they didn’t have enough time for ‘hands on’ for very small babies”.⁹⁹ This comment also reflected another contradictory position where Jenny was simultaneously encouraged and expected to go on caring for David. On one occasion failing to meet this expectation brought with it a consequence which remained vivid in Jenny’s memory.

⁹⁶ Oral history interview with Jenny, 4 September, 2001.

⁹⁷ Oral history interview with Jenny, 4 September, 2001.

⁹⁸ Oral history interview with Jenny, 4 September, 2001.

⁹⁹ Oral history interview with Jenny, 4 September, 2001.

He was in isolation, he hadn't been seen to for hours. I went in and he'd cut himself on a toy and there was blood everywhere and that was only on one occasion that I'd gone out and left him for a period of time.¹⁰⁰

The literature pointed to the child's emotional 'needs' as the main reason for having mothers resident in the ward, maintaining their usual child care routines. However, in the context of Jenny's experience, it appeared that she was both encouraged and expected to continue the everyday tasks of child care to meet the 'needs' of the organisation. From Jenny's perspective collaboration presented itself as a double-edged sword. On the one hand she remembered feeling like an equal partner with the nurse because, as she told me:

Well as he [David] got older some of his things the nurses had never done. So I would do his bladder washout or help. They didn't know what they were doing and they appreciated that I could be there to do it.¹⁰¹

On the other she described it as a *fait accompli* and explained that "I felt that if I didn't join them I wouldn't know what was going on and I wanted the best for David's care".¹⁰²

Several publications in the 1970s and early 1980s pointed out that having mothers resident in the ward did not mean that nurses simply abandoned the care of the child to the mother. Instead, they adjusted their role to one of support and help for the mother. Implicit in this view was the suggestion that both the mother and the child would be regarded as the focus of care. Arguably this expressed a shift in thinking beyond the needs of the child and suggested recognition of the influence that broader contextual factors might have on a mother's ability to care for her child while in hospital. However, these implications for care were not addressed

¹⁰⁰ Oral history interview with Jenny, 4 September, 2001.

¹⁰¹ Oral history interview with Jenny, 4 September, 2001.

¹⁰² Oral history interview with Jenny, 4 September, 2001.

in the literature. Clearly the emphasis on ‘help’ and ‘support’ remained limited to the mother-child dyad within the context of the ward environment. When ‘family-centred care’ was viewed from this perspective it was not surprising that, as Jenny’s story revealed, nurses regarded and responded to live-in mothers as though they existed in a social vacuum. Jenny remembered “getting flak”¹⁰³ from her mother for living-in with David and not spending enough time with her daughter. However, on the occasions that Jenny’s daughter was with her in the ward she recounted how difficult it was and described a time that

I had my daughter in and she was starving, it was mealtime. There was a meal left but I wasn’t allowed the meal for my daughter and I couldn’t get out to go and buy something. At that stage children weren’t allowed in the cafeteria...so she was crying because she was hungry and I was trying to feed David. They [the staff] wouldn’t share anything that was left. Even a sandwich would have been wonderful.¹⁰⁴

When I asked Jenny if there was one thing that she would have changed about her experience of living-in she told me that “it would be if they’d accepted my family as a family, more than just David and myself, so that I didn’t have to push my daughter away. That’s what I would have liked to change”.¹⁰⁵

Nursing reality

This section describes the practice reality of one nurse working in the children’s ward during the 1980s. It examines the impact that live-in parents had in the context of the children’s ward. Claire’s account suggested that the varying attitudes towards live-in parents placed nurses in contradictory positions. These contradictions were subsequently reflected in an approach to practice that often appeared paradoxical. These

¹⁰³ Oral history interview with Jenny, 4 September, 2001.

¹⁰⁴ Oral history interview with Jenny, 4 September, 2001.

¹⁰⁵ Oral history interview with Jenny, 4 September, 2001.

experiences are examined with reference to the professional literature published at this time.

Claire was appointed Charge Nurse of the children's ward in the early 1980s and she emphasised that "I had undertaken specific training I guess to be in that role".¹⁰⁶ Most of Claire's 'specific training' had been undertaken overseas. In addition to her midwifery qualification, she was also a registered sick children's nurse having completed the post-registration course at The Hospitals for Sick Children, Great Ormond St. London. Similar to Helen's description of working in the same children's hospital twenty years prior, Claire also commented that "it was the first time I had ever worked in a children's hospital. It seemed to me to be quite a different atmosphere and thinking than a children's ward within an adult hospital".¹⁰⁷ This was in direct contrast to the attitudes towards parents that Claire had witnessed as a student in the early 1970s, during her assignment to the children's ward, when visiting hours were inflexible and strictly enforced by the sister in charge of the ward. The literature has indicated that even in the 1970s, dependent on the forum, parental protest against restrictive hospital practices met with varying success. In accordance with this Claire told me that "I don't remember at that stage parents bucking the system".¹⁰⁸ Having heard about the Platt Report during her hospital training, it bothered her that children were without parental support at a time when arguably they needed it the most. Ironically, the theory-practice gap was highlighted by Claire's next remark that "the structure of the hospital at that time didn't allow that [extended parental presence] nor was it encouraged".¹⁰⁹

¹⁰⁶ Oral history interview with Claire, 9 September, 2001.

¹⁰⁷ Oral history interview with Claire, 9 September, 2001.

¹⁰⁸ Oral history interview with Claire, 9 September, 2001.

¹⁰⁹ Oral history interview with Claire, 9 September, 2001.

The literature has pointed to the support for the recommendations of the Platt Report at a government level. However, proposals to hospital boards were only advisory in nature and consequently implementation remained at the discretion of individual boards. In addition to a hospital structure that did not appear to be supportive of extended parental presence, Claire also remembered the attitude of some medical staff towards parents.

I remember ward rounds in particular, the medical staff would not want parents to be there when they were doing the round because they would interrupt and ask questions and they would have to talk to them. It was much easier for them to do the ward round without those interruptions...it was the days perhaps when the doctor thought that he knew what was right and what wasn't right.¹¹⁰

The impact that these attitudes had on the day to day life of the children's ward was illustrated by Claire when she concluded that "well for those who had different ideas the nurse was the meat in the sandwich between families and how the system ran".¹¹¹ Clearly this comment characterised the contradictory position of the nurse which I referred to earlier as 'clinical expediency versus mutuality'. However, it was not until the 1980s that the literature began to suggest that changes in children's hospital care required a move away from the formally organised wards of the past and demanded from staff a new approach to care.

Clinical expediency versus mutuality

By the early 1980s it appeared that some of the earlier restrictions governing parental presence had been relaxed and there was a tacit acceptance of resident parents. However, as the literature has suggested, acceptance in principle was not always reflected in practice. Jenny's account suggested that the provision of physical facilities that enabled parents to stay signalled the hospital's acceptance. Interestingly though, Claire noted that the hospital's live-in beds were limited and

¹¹⁰ Oral history interview with Claire, 9 September, 2001.

¹¹¹ Oral history interview with Claire, 9 September, 2001.

that many parents could only be accommodated by the generosity of people who donated comfortable reclining chairs and camp stretchers.

Together with the provision of physical facilities, it was also recognised that a new style of care, in particular nursing care, was required in the children's ward. However, literature revealed minimal accompanying commentary that described an appropriate framework for this new style of practice, or any discussion as to how it would be applied in the context of the traditional hospital structure. Claire's account suggested that, while in principle there appeared to be an acceptance of extended parental presence, in practice the contradictions remained. Although a charge nurse, Claire recounted her experiences of ward rounds reminiscent of those she witnessed as a student.

I can remember vividly on many occasions doing a ward round and either moving parents along as the doctors were coming because they didn't want to speak to the parents. Or making sure that they [parents] stayed there because we had discussed what they were going to say and that they felt okay about it if the doctors were grumpy. I felt that the nursing staff were appreciative of any involvement for the children that necessitated their recovery and it was their family.¹¹²

Implicit in this account was the contradictory position in which Claire found herself. I would suggest that this was subsequently reflected in her paradoxical approach to practice. Claire's action of 'moving parents along' reflected an assumption that traditional ward routines such as ward rounds demanded clinical expediency. The presence of parents disrupted this orderly process. On the other hand, preparing some parents beforehand and 'making sure they stayed' suggested a sense of mutuality with parents that challenged the boundary between professional and parent.

However, the contradiction between clinical expediency and mutuality was not necessarily apparent in the practice of every nurse in the ward. In fact

¹¹² Oral history interview with Claire, 9 September, 2001.

Claire stressed that “I think a lot of nurses felt and knew that they couldn’t manage all the things for the child without the parents being there because they had a lot of work to do”.¹¹³ This suggested a position whereby clinical expediency was the nurse’s only concern. Consequently a distinction had to be made between ‘expert’ care for which the professional was responsible and ‘inexpert’ care which would become the parents’ responsibility. This was not dissimilar to Jenny’s account of why she was encouraged to become involved in her son’s care. During the interview Claire wondered about the reasons why parents were now expected to become involved, and she concluded that “nurses became much busier and seemed to be doing more medical things and then we perhaps expected the parents to do more”.¹¹⁴ Parental presence was viewed pragmatically. Correspondingly the relationship between parent and nurse was not mutual but based on an expectation that the parent would be of help to the nurse. For instance, this was highlighted when Claire remarked that “there was also an element of the parents asking questions and it was stressful for them [staff] and also they [parents] get in our way”.¹¹⁵ Claire believed that the attitudes of senior hospital management, nursing and medical, towards live-in parents showed little understanding of the accompanying implications for nursing practice. She told me that “the hospital senior management didn’t have any idea what it was like in the paediatric area. They considered that if a child had a parent with them that it reduced the nursing workload”.¹¹⁶ However, it could be argued that nurse’s expectations of parent’s help, rather than supporting them to help, paradoxically perpetuated this myth. Claire alluded to this when she added “it depends on you as a nurse as to how you get involved with your family”.¹¹⁷

¹¹³ Oral history interview with Claire, 9 September, 2001.

¹¹⁴ Oral history interview with Claire, 9 September, 2001.

¹¹⁵ Oral history interview with Claire, 9 September, 2001.

¹¹⁶ Oral history interview with Claire, 9 September, 2001.

¹¹⁷ Oral history interview with Claire, 9 September, 2001.

Maintaining versus breaking the boundaries

The phrase, 'how you get involved', suggested the development of collaborative relationships with families that would challenge the traditional boundary between professional and parent. Jenny's account suggested that the boundary between the 'expert' professional and the 'inexpert' parent was not so obvious in the 1980s. However, as the literature suggested, this may have reflected Jenny's previous experiences with 'experts'. The literature also pointed out that although live-in mothers were usually thought of as another carer, this was further defined by nursing and medical staff in relation to their own roles as carers. This suggested that medical and nursing staff were free to define their own individual roles within the traditional hospital structure. However, this view did not take into account the intensely hierarchical nature of staff roles within the hospital and the way in which those roles had historically maintained the boundaries between professionals. Claire's paradoxical response to live-in parents on the ward round indicated that, while on the one hand she may have defined her role and the live-in parent's role as mutual, on the other hand in doing so it contradicted the expectation of the nursing role which was further defined in relation to the traditional hospital structure. In other words, the nurse's role now contained in it another contradiction, the necessity to maintain and break down the boundaries.

Claire's story revealed that hospital visiting hours remained as the method by which the ward's physical boundaries would be maintained. Administering these remained the nurse's responsibility.

We had to be strict on how many numbers were at the bed and visiting time was limited. In the new hospital we were able to have twenty-four hour for parents and separate times for other people. It was part of the duties of the nurses to have the doors closed. I don't know how many signs we had up about visiting hours they seemed to go missing from time to time and we would have to put them up again. There were bells to ring when visiting time was over...there

were always discussions about how many people had how many people.¹¹⁸

Visiting hours that distinguished between parents and ‘other people’ also applied a personal boundary. ‘Family’ was defined according to hospital assumptions of parent-child relationships and deemed applicable to everyone. Claire remembered that

I found it was very difficult for parents because sometimes when they had a child perhaps in isolation and yet they had others at home to look after as well you couldn’t not let an aunty come and stay...you know you had to be lenient. Many a discussion you would have with families about bucking the rules...and many an argument with a consultant about why so and so were here when it wasn’t the rules.¹¹⁹

Summary of parental and nursing reality

Jenny and Claire’s accounts, while not able to be generalised as reflective of the experiences of other parents or nurses in the 1980s, nevertheless pointed to the impact that changes in the care of the hospitalised child had for both parents and nurses in one hospital. The reviewed literature suggested that contradictions existed between ‘expert’ rhetoric and current attitudes and ideas about motherhood and childhood during the 1970s and 1980s. Both Jenny and Claire’s experiences suggested the presence of contradictions in practice. However, when these experiences were considered in relation to the reviewed nursing, medical and related literature the theoretical and practice contradictions were revealed. During the 1970s and 1980s professional nursing and medical commentary still reflected the ‘service’ style of motherhood. It continued to advance the separation thesis as the fundamental reason that extended parental presence in the children’s ward was necessary and in some instances used it as criterion to determine whether a parent would be able to live-in. This was in contrast to changing societal attitudes towards motherhood and childhood. Central to the new paradigms of motherhood and childhood

¹¹⁸ Oral history interview with Claire, 9 September, 2001.

¹¹⁹ Oral history interview with Claire, 9 September, 2001.

were the rights of both to an autonomous self. In the context of the hospital children's ward these new ideas were reflected as some parents demanded the right to live-in with their child if they so wished regardless of its age.

Jenny's account revealed no evidence to suggest that the tenets of Bowlby's maternal deprivation thesis had influenced her living-in experience. In fact she had never heard of the separation thesis although, in the literature, this thesis remained the central reason for extended parental presence. However, any concern over Jenny's unfamiliarity with Bowlby's theory appeared unwarranted when considered alongside Claire's account. Unlike Jenny, Claire had learnt about the separation thesis in her hospital training. However, it remained a theoretical concept that bore little relation to hospital practice. Professional rhetoric and practice reality therefore, appeared contradictory. Both Jenny and Claire's experiences suggested that while in practice Bowlby's theory appeared mute, the ideological assumptions about mothers contained in it were still evident. Far from reflecting the new motherhood as life experience paradigm, Jenny's experience of living-in described a new style of 'motherhood as service' whereby the mother's presence and involvement in care was expected and encouraged in order to 'service the needs' of the busy hospital organisation. Although the hospital had physically opened its doors to parents their presence was viewed pragmatically and overlooked the impact that broader contextual factors had on a parent's ability to care for their child while in hospital. Jenny and Claire's experiences both suggested that, as a result, parents and nurses often found themselves in challenging and contradictory positions.

CHAPTER 5:

Discussion

The study of history can do much to develop our ability to examine the present critically. Understanding how nurses reinforced the dominant values and attitudes of their society in the past forces us to examine our relationship with our clients in the present..¹

This historical study has illustrated the evolutionary nature of the concept of ‘family-centred care’ in both its British and local New Zealand contexts. As a model of care appropriate to the hospital children’s ward in New Zealand, interpretation and implementation of the concept has developed and changed while some aspects have remained constant. Current nursing literature points to the paradox of ‘family-centred care’. Coyne has suggested that if the family is not the focus of care then using the term ‘family-centred care’ is erroneous. She goes on to question the appropriateness of the term ‘parent’ for current nursing practice and states that “more mothers are now in full-time employment and grandparents, guardians, step-parents and child-minders act as prime caregivers. Family-centred care may preclude parent participation if this is not conducive for healthy family functioning”.² Similarly, Clayton contends that contemporary hospital services for children reflect an ideology of family responsibility for care in the guise of ‘family-centred care’.³

In the 1950s and 1960s application of the concept to the hospital children’s ward was mainly reactive in response to the changing context in which ‘experts’ viewed children. In the context of the hospital children’s ward this was reflected in a new concern for the emotional and developmental needs of the sick child. However, this intensely child-centred view of

¹ S. Brennan, ‘Nursing and motherhood constructions: implications for practice’, *Nursing Inquiry*, 5, 1998, p. 16.

² I. Coyne, ‘Parent participation: a concept analysis’, *Journal of Advanced Nursing*, 23, 1996, pp. 733-740.

³ M. Clayton, ‘Health and social policy: influences on family-centred care’, *Paediatric Nursing*, 12, 8, 2000, p. 33.

family life advanced a one-dimensional view of the concept of ‘family-centred care’ and focused almost exclusively on the young child and its mother. The experience of mothering in New Zealand during the 1950s and 1960s was defined as ‘motherhood as service’ and indicated that mothers would adjust their lives according to the needs of their children.

Although the New Zealand nursing and medical rhetoric during the 1960s supported this ideological shift which considered mothers fundamental for children’s emotional health and well being, oral evidence from the 1960s revealed that ‘expert’ rhetoric did not always reflect the realities of practice in one hospital children’s ward. Bowlby’s theory of maternal deprivation offered ‘scientific’ justification that allowed mothers freer access to hospital children’s wards. However, the experiences of Mary and Helen suggested that in one New Zealand hospital interpretation of what it was that constituted ‘family-centred care’ was clearly the prerogative of medical and administrative ‘experts’. The reality of ‘family-centred care’ for some mothers and nurses was therefore, mediated through the formalised hospital system. Accordingly, support for this concept in practice was viewed entirely in professional and organisational terms.

By the 1970s and 1980s there were signs that the status of both childhood and motherhood in New Zealand were once again in a state of flux. The contextual literature pointed to the emergence of new attitudes towards children and mothers during this time period. The women’s movement gave rise to a new paradigm of motherhood, ‘motherhood as life experience’, whereby motherhood was redefined as one of many life experiences open to women. Similarly attitudes towards children were also shifting and a social justice model emerged which stressed that children, as a separate societal interest group, also had rights within society. New Zealand nursing and medical literature concerned with the care of the hospitalised child did not, however, reflect these changing societal attitudes and instead continued to promote psychological theories and the ‘service’ style of motherhood. Accordingly, there was no further development of the

concept of 'family-centred care' and implementation in practice did not take into account the changing nature of New Zealand families.

Tangible evidence of this was revealed in the oral history accounts of Jenny and Claire. Their experiences pointed to the contradictions that existed between the theory and practice of 'family-centred care'. Professional nursing and medical commentary continued to promote the separation thesis, as the central reason that continued parental presence was necessary in the hospital children's ward. In contrast, Jenny and Claire's accounts revealed that in practice the tenets of the separation thesis appeared mute. Jenny was not familiar with the separation thesis but nevertheless assumed she would be able to live-in with her son and Claire's account suggested that the separation thesis remained a theoretical concept that had little impact on ward practice. However, vestiges of this theory and the ideological assumptions about mothers contained within it remained and Jenny and Claire's experiences both suggested that this influenced how 'family-centred care' was enacted in one hospital children's ward. In the context of one hospital children's ward the practice of 'family-centred care' reflected a professional reinterpretation of the 'motherhood as service' paradigm whereby the presence of mothers now appeared to be essential in order to 'service' the needs of the busy hospital ward. This purely pragmatic understanding of 'family-centred care' ignored the influence that broader contextual factors such as culture, geographical location, socio-economic structures, past experiences, household composition, community and social support networks all had on a parents ability to care for their child while in hospital.

A comparison of the oral history accounts from mothers and nurses in the 1960s and 1980s revealed that although 'family-centred care' had changed in many ways, much had also remained the same. Jenny's experience suggested that the practice of some senior nursing staff in the 1980s was not dissimilar to that experienced by Mary in the 1960s when hospital rules and routines took precedence over the needs of patients. Although 'family-centred care' had been defined and carefully controlled mainly by medical

and administrative hospital ‘experts’ in this hospital since the 1960s, the role of parent as an ‘agitator for change’ in the hospital children’s ward was revealed in both Mary and Jenny’s account. In the 1960s Mary’s husband challenged the restrictive visiting hours of the hospital children’s and in the 1980s Jenny remembered that on occasions she would ‘push it’ with professional staff in order to achieve whatever she felt was in her son’s best interests. Jenny was able to live-in with her son in the 1980s, unlike Mary who was subject to strictly enforced rules that prescribed when she would be able to ‘visit’ her son. However, Jenny and Claire’s accounts revealed that although parents in the 1980s had more liberal access to their hospitalised child, ‘visiting hours’ remained and were now used to limit the access of ‘other’ people who were not the child’s parents. As with the professional response in the 1960s, ‘family’ in the 1980s was still defined according to hospital assumptions of parent-child relationships and considered applicable to everyone.

There were similarities in both mothers’ accounts with regard to the way in which access to information about their child’s care was used to maintain boundaries between ‘inexpert’ parents and ‘expert’ staff. In the 1960s Mary described access to information about her son as nothing more than “hearing a little bit”⁴ if she happened to be present when the surgeon did his rounds. Mary’s choice of the word ‘hear’ is of interest because it implies that it is by accident that the parent ‘hears’ information regarding their child’s progress. This suggests that in one hospital children’s ward during the 1960s professional staff controlled information, and decisions regarding the child’s care were made on behalf of the family because professionals believed they knew best. These views prevailed into the 1980s and Claire’s accounts of “moving parents along”⁵ before the ward round reflected this. Parental questions and concerns were dismissed by medical staff as unnecessary ‘interruptions’ that interfered with the traditional routines. That some parents were living-in with their children in

⁴ Oral history interview with Mary, 18 September, 2001.

⁵ Oral history interview with Claire, 9 September, 2001.

the 1980s suggested that boundaries between professional and parent would be less obvious. However, Jenny explained living-in as a way of 'joining' the professional staff so she would "know what was going on"⁶ with her son's care. This account suggested that an uneasy alliance was formed with staff based on a climate of mistrust rather than trust. This theme prevails and is highlighted in a 1998 New Zealand report, 'Through the Eyes of a Child'.⁷ One question asked, 'were services focused on your child and whanau'?⁸ Of the 151 people who responded to this question 22% said that 'yes' services were child focused but not family focused. From a parents perspective one respondent noted that "staff did not establish trust with us. They focused on 'doing-to' and not 'doing with'".⁹

Being mindful and aware of 'family' needs in addition to the sick 'child's' needs was a plea from both mothers that echoed, largely unheard, across the decades. Hospital enforced rules had physically restricted other family members from participating in Mary's sons hospital care during the 1960s. Professional care was focused entirely on the needs of the sick child. Parents were viewed as intruders at best and detrimental to their child's care at worst. Both these discourses surrounding parents were reflected in Mary and Helen's accounts. Mary described feeling like an "interloper"¹⁰ in the ward and in an effort to restrict visiting hours Helen suggested, in a report to the hospital administration, that visitors could prove detrimental to a child's hospital care. However, it is clear from Jenny's experience of this same hospital twenty years later that professionals continued to focus exclusively on the needs of the sick 'child'. This was in contrast to a shift

⁶ Oral history interview with Jenny, 4 September, 2001.

⁷ This report was part of the national review of paediatric speciality services undertaken by the Health Funding Authority and the Paediatric Society of New Zealand. It summarised the findings of the public consultation with parents, community groups and interested individuals on the delivery of paediatric speciality services for children in New Zealand. It was carried out during April and May 1998.

⁸ Whanau is the Maori word for family.

⁹ 'Through the Eyes of a Child', September, 1998, p. 26.

¹⁰ Oral history interview with Mary, 18 September, 2001

in practice that now accommodated parents in the ward and expected that they would become involved in their child's care. The implications of this for Jenny were revealed when she described that although she was not physically prevented from having her other child present difficulties arose because the nature of other hospital policies precluded effective parenting of children other than the sick child. Professional implementation of 'family-centred care' failed to take into account these other 'family' needs and were reflected in Jenny's expression of regret that she had had to "push her daughter away"¹¹ in order to care for her hospitalised son.

The quotation that opened this chapter suggests that developing an awareness of how nurses in the past reinforced society's dominant attitudes and values enables us to critically examine our current practice.¹² Professional nursing commentary in New Zealand nursing literature in the 1960s reinforced a general societal concern for the healthy psychological development of the young child and the responsibility of mothers for that development. Medical commentary at this time advanced the tenets of Bowlby's separation thesis as the fundamental reason for changes in the hospital children's ward. This 'scientific' rationale enabled doctors to set the parameters of the debate. In the context of the hospital children's ward doctors were responsible for the medical treatment of children. Medical discourse incorporated 'family-centred care' in terms of a medically sanctioned 'treatment' that in some instances was viewed to be in the best interests of their 'child' patient. When the presence of mothers was encouraged it was done so from an entirely professionally centred view of care and believed to be either medically beneficial to the child or as a way of educating mothers. This belief clearly delineated between the 'expert' professional and the 'inexpert' parent and this attitude was supported, largely unchallenged, in the professional nursing literature.

¹¹ Oral history interview with Jenny, 4 September, 2001.

¹² S. Brennan, p.16.

Helen's oral history account from the 1960s suggested that in one hospital children's ward nurses bore the brunt of these new attitudes. This was clear from Helen's report to the hospital administration concerning the effects that prolonged visiting hours had on nursing practice. This report highlighted that although extending visiting hours within this hospital children's ward was seen as "keeping up with recent trends",¹³ it impacted on the nurse's ability to carry out her work in a timely and efficient manner. In other words practice needed to be seen to be changing yet paradoxically it needed to remain the same lest it pose a challenge to the traditional hierarchical roles of professionals within the hospital.

Promotion of the separation thesis was a continuing theme throughout New Zealand medical and nursing publications between 1970 and 1980 concerned with the hospital care of children. In keeping with this discourse, the 'service' notion of motherhood was reflected in most of the professional articles and 'family-centred care' was focused solely on the 'needs' of the 'child' patient. However, contained in some nursing commentary during this time was the suggestion that the tenets of separation thesis did not address the practical implications of 'family-centred care' in the children's ward, nor did it reflect the changing nature, both socially and economically, of New Zealand families.

The challenges of enacting a new style of 'family-centred care' in the 1980s were revealed in Claire's oral history account. Like Helen, Claire remained bound by a medically dominated hospital system. Doctors' attitudes towards the presence of parents in this children's ward appeared unchanged since the 1960s and continued to dictate the parameters by which parents would be allowed access to their child while in hospital. In contrast to Helen's experience, however, Claire's story suggested that in the 1980s nurses viewed themselves as 'mediators' in changing attitudes towards 'family-centred care'. Yet paradoxically nursing actions that 'moved parents along' prior to a ward round, and administered visiting

¹³ Oral history interview with Helen, 5 October, 2001.

hours that defined who was ‘family’ according to an organisational assumption of parent-child relationships arguably perpetuated the existing ambivalence and, in some instances, intolerance of parental presence. Claire’s account suggested that nurses who viewed ‘family-centred care’ as focusing on the ‘needs’ of the family in addition to the ‘needs’ of the hospitalised child were rare. It also revealed that administrative and medical expectations of the nursing role remained largely unchanged in this hospital. What had changed, however, was the nursing response. In the 1960s Helen had restricted visiting hours in an effort to ensure there would be no appreciable disruption to established routines and nurses could complete their work without parental interruptions. By the 1980s, while the premise remained the same, the action that would achieve it had changed. Rather than restricting the mother’s presence it was now encouraged based on an expectation that she would be of help to the busy nurse.

Implications for the current practice of ‘family-centred care’ in New Zealand

Current practice implications revealed by this study highlight that the historical assumptions inherent in ‘family-centred care’, that applied professional ‘rule of thumb’ approaches to all families, remain embedded in our current understanding of the concept. For instance a recent article published in the *New Zealand Nursing Journal*, that discussed ‘family-centred care’ in practice, suggested that

if nurses take the time to enter into genuine dialogue and negotiation with the family, they can save themselves considerable work. Parents/carers want to be fully involved in their child’s care. And if a nurse has to spend less time on some aspects of a child’s care, the nurse will have more time to educate the child and parents/carer.¹⁴

These statements further suggest that the contradictions of clinical expediency versus mutuality evident in the practice of nurses in the 1980s still prevail.

¹⁴ D. Connor, ‘Family-centred care in practice’, *Kai Tiaki: Nursing New Zealand*, May 1998, p. 19.

Implementing 'family-centred care' in the context of the hospital children's ward is reliant on more than just a ward philosophy or a managerial mission statement that mandates it. Helen and Claire's oral evidence strongly suggests that as individuals we may strive to deliver care that is focused on the 'needs' of the family in addition to the 'needs' of the sick child. This, however, is unlikely to be successful if the organisational structure, within which health services are delivered, does not provide resources that acknowledge and support a 'family focused' (as opposed to a solely 'child focused') approach to care. Claire and Jenny's descriptions of 'family-centred care' prompt us to consider whether our current understanding of the concept has indeed evolved. Or is implementation based on an organisational and ward culture that assumes and expects families to provide care, rather than assesses whether it is appropriate? Positioning the concept of 'family-centred care' within the broader context of ideas and beliefs about mothering and children that emerged in New Zealand society between 1960 and 1980 has suggested that as nurses we must be mindful of the influence that societal attitudes have on our ability to work with families in a truly non-judgemental way. As Sue Thomsen points out, "in today's multicultural society paediatric nurses constantly work with children and families from different cultures. The diversity of cultural backgrounds means nurses must acknowledge that while a child's health needs may be the same, the way those needs are met can be diverse".¹⁵

Conclusion

This study has addressed the historical development of 'family-centred care' in its New Zealand context and positioned it within the broader context of ideas and beliefs about mothering and children in New Zealand society between 1960 and 1980. It has revealed that the practice paradoxes of 'family-centred care' are historically enduring, although vary in their enactment, and as a result, continue to influence current approaches to the practice of 'family-centred care' in the hospital children's ward. The

¹⁵ S. Thomsen, 'Making family-centred care a reality', *Kai Tiaki Nursing New Zealand*, May 1998, p. 15.

juxtaposition of oral evidence from 1960 and 1980 with New Zealand nursing, medical and related literature between these time periods highlighted that ‘expert’ rhetoric supporting change in the care of the hospitalised child did not match the reality in one New Zealand hospital. In this hospital children’s ward during the 1960s the experience of ‘family-centred care’ for one mother and one nurse was regulated by the formalised hospital system. It was therefore, not surprising that themes such as ‘abiding by the rules’ and ‘breaking the rules’ were consistent throughout the account of one mother’s hospital experience. The literature suggested that implementing ‘family-centred care’ often placed nurses in challenging and contradictory positions and the oral evidence provided by this study supports that contention. One nurse’s account from the 1960 pointed to the contradiction in practice that ‘family-centred care’ presented for the nurse. ‘Family-centred care’ had a significant impact on the nursing role but this was not acknowledged and medical and organisational expectations of the nursing role remained the same. In response, one nurse found it necessary to restrict visiting hours, on the other she spoke of ‘the right thing to do’ subverting her own rules in an effort to provide care that attended to the child’s and the families needs.

The professional nursing and medical literature continued to focus on the care of children sick and well, throughout the 1970 and 1980s. However, the professional literature did not take into account changing societal attitudes and beliefs about mothering and children. The understanding of ‘family’ presented in the majority of professional literature, pertinent to the care of the hospitalised child, continued to advance a view that assumed it was appropriate and acceptable for all mothers to provide care for their child while in hospital. Oral evidence provided by one mother who lived-in with her child in the 1980s suggested that these assumptions placed mothers in contradictory positions within the ward environment. This mother’s account revealed the contradiction of ‘collaboration versus conflict’ as she struggled with meeting the competing demands of her family and hospitalised child. Oral evidence from one nurse attempting to implement ‘family-centred care’ in this hospital in the 1980s indicated that

practice contradictions prevailed despite a tacit acceptance of extended parental presence. Although parents were clearly part of the ward environment, medical and organisational expectations of the nursing role remained largely unchanged since the 1960s. The contradiction of ‘clinical expediency versus mutuality’ described the practice reality for one nurse in one hospital children’s ward in the 1980s. This nurse’s account also suggested that contradictions in practice were more complex in the 1980s and this nurse described the delicate balancing acts required of her, on the one hand to maintain traditional hospital boundaries, while on the other, to break them down in an attempt to implement care that was ‘family’ centred.

The historical paradoxes of ‘family-centred care’ prevail in current practice and this study has presented us with the opportunity to reflect on the implications of these for children and families currently in our care. We must ask ourselves if ‘family-centred care’, as currently conceived in our New Zealand hospital children’s wards, reflects the continually changing nature of New Zealand families and, if not, whether we are prepared to challenge hospital environments that only pay lip service to the concept.

APPENDICES:

Nurse information sheet - Appendix 1

**Victoria University of Wellington
Graduate School of Nursing and Midwifery**

NURSE PARTICIPANT INFORMATION SHEET

The Experiences of Some Parents and Nurses Caring for a Child in a New Zealand Hospital, 1960-1990.

Principal Investigator: Kim Chenery - Phone contact 03-337-5119

Thank you, for considering taking part in this study. My name is Kim Chenery. I am the investigator in this study and a student of the Graduate School of Nursing and Midwifery at Victoria University of Wellington. This study is part of the requirements for the Master of Arts (Applied) Degree I am enrolled in.

I am a registered nurse and have worked in various paediatric areas for seventeen years. This study has grown out of my interest in family-centred care that acknowledges the child's family as central to his/her life. This model of care realises the importance of nurses working with families to plan care that is appropriate and acceptable to both the child and the family. This is not a new concept, but has been an evolving one since the late 1950s.

The objectives of this study are:

- To record the experiences of nurses who were involved in the care of children in a New Zealand hospital, 1960-1990.

I am interested in talking to you about your experience of caring for a child (or children) in hospital at a time when greater parental participation in care was being encouraged. This may, or may not have been your experience. I would ask you to think back to that experience and your interpretation of the beliefs and attitudes (your own and of others) that may have shaped this experience for you.

If you were interested in being a participant in this project, I would interview you at a time and place agreeable to you. The interview might last about an hour, or an hour and a half. I would audiotape the interview. The audiotape would be kept securely stored during the project. My supervisor Dr. Pamela Wood would also have access to the audiotape. No one else would have access to it unless you give your consent. At the end of my study, I would store the tape securely for five years, then wipe it electronically, unless you agree to it being stored in some other way. I will also give you your own copy of the audiotape if you would like one.

As part of this study, I also need to include quotations from the interview in my thesis. Any information you provide will not be attributed to you by name. Excerpts from transcripts of the interview will be included in the research report. Your participation in this project is entirely voluntary. If you decide to participate, I will ask you to sign a written consent form. You can stop the interview at any time, or withdraw from the project at any at any point until analysis of the interview data commences.

The Human Ethics Committee, Victoria University of Wellington, has approved this study.

If you would like more information about my course, or the study I am doing, you can contact my supervisor Dr. Pamela Wood n the Graduate School of Nursing and Midwifery, Victoria University of Wellington, P.O. Box 600, Wellington, New Zealand, or by phoning (04) 463-6650.

Parent information sheet – Appendix 2

Victoria University of Wellington Graduate School of Nursing and Midwifery

PARENT PARTICIPANT INFORMATION SHEET

The Experiences Some of Parents and Nurses Caring for a Child in a New Zealand Hospital, 1960-1990.

Principal Investigator: Kim Chenery - Phone contact 03-337-5119

Thank you, for considering taking part in this study. My name is Kim Chenery. I am the investigator in this study and a student of the Graduate School of Nursing and Midwifery at Victoria University of Wellington. This study is part of the requirements for the Master of Arts (Applied) Degree I am enrolled in.

I am a registered nurse and have worked in various paediatric areas (care of children) for seventeen years. This study has grown out of my interest in family-centred care that acknowledges the child's family as central to his/her life. This model of care realises the importance of nurses working with families to plan care that is appropriate and acceptable to both the child and the family. This is not a new concept, but has been an evolving one since the late 1950s.

The objectives of this study are:

- To record the experiences of parents during their child's hospitalisation in a New Zealand hospital, 1960-1990.

I am interested in talking to you about your experience of having a child in hospital at a time when greater parental participation in care was being encouraged. This may, or may not have been your experience. I would ask you to think back to that experience and your interpretation of the beliefs and attitudes (your own and of others) that may have shaped this experience for you.

If you are interested in being a participant in this project, I would interview you at a time and place agreeable to you. The interview might last about an hour, or an hour and a half. I would audiotape the interview. The audiotape would be kept securely stored during the project. My supervisor, Dr. Pamela Wood would also have access to the audiotape. No one else would have access to it unless you give your consent. At the end of my study, I would store the tape securely for five years, then wipe it electronically, unless you agree to it being stored in some other way. I will also give you your own copy of the audiotape if you would like one.

As part of this study, I also need to include quotations from the interview in my thesis. Any information you provide will not be attributed to you by name. Excerpts from transcripts of the interview will be included in the research report.

Your participation in this project is entirely voluntary. If you decide to participate, I will ask you to sign a written consent form. You can stop the interview at any time, or withdraw from the project at any point until analysis of the interview data commences.

The Human Ethics Committee, Victoria University of Wellington, has approved this study.

If you would like more information about my course, or the study I am doing, you can contact my supervisor Dr. Pamela Wood in the Graduate School of Nursing and Midwifery, Victoria University of Wellington, P.O. Box 600, Wellington, New Zealand, or by phoning (04) 463-6650.

Interview outline sheets – Appendix 3

The Experiences of Some Parents and Nurses Caring for a Child in a New Zealand Hospital, 1960-1990.

Oral History Interview Outline – Parent Participant

Please treat the following questions as a ‘memory jogger’ only, you may have other memories and thoughts about the experience of having your child admitted to hospital that you may wish to tell me about.

- What year was your child admitted to hospital?
- How old was your child at the time of their hospital admission?
- How long was he/she admitted for?
- At that time did you have an expectation of being able to ‘live-in’ with your child or at the very least have unrestricted access to your child?
- At this time, were you aware of a movement urging hospitals to accept the idea that mother’s of young children should remain with them? If so, who or what were your sources of information regarding these new ideas?
- Thinking back to when your child was in hospital, in what way were you involved in his/her care?
- Were you encouraged by nursing or medical staff to become involved in the decisions regarding your child’s care?
- How did you feel about your involvement (or lack of involvement) in the hospital care of your child?
- Can you recall the attitudes of nursing and medical staff towards parents?
- When your child required hospitalisation was it your expectation that responsibility for their welfare would naturally be handed over to the ‘professionals’? If so, what factors influenced your thinking?
- Thinking back to the time when your child was admitted to hospital, is there any one word or phrase that sums up the whole experience? Can you tell me why?
- What, if anything, would you have liked to change?

The Experiences of Some Parents and Nurses Caring for a Child in a New Zealand Hospital, 1960-1990.

Oral History Interview Outline – Nurse Participant

Please treat the following questions as a ‘memory jogger’ only, you may have other memories and thoughts about the experience of nursing in a children’s ward that you may wish to tell me about.

- What was your rank when you worked in the children’s ward?
- Had you undertaken any specific training to work in the children’s ward? If so what was the nature of this training?
- At this time, were you aware of a movement urging hospitals to accept the idea that mother’s of young children should remain with them? If so, who or what were your sources of information regarding these new ideas?
- What was your experience of parental involvement in care when you worked in the children’s ward?
- Did senior nursing or medical staff encourage parents to be resident and involved in the care of their hospitalised child?
- What factors do you think influenced the responses (either positive or negative) of senior nursing and medical staff?
- What was your interpretation of the beliefs and attitudes that ward staff held regarding resident parents? Do you think that the attitude of the senior staff influenced these attitudes?
- Can you recall your own attitudes and beliefs regarding resident parents?
- What factors do you think influenced these attitudes?

Consent form – Appendix 4

**Victoria University of Wellington
Graduate School of Nursing and Midwifery**

CONSENT FORM

***The Experiences of Some Parents and Nurses Caring for a Child in a
New Zealand Hospital, 1960-1990.***

I have been given an explanation of the study, which is part of the requirements for the Master of Arts (Applied) Nursing, at Victoria University of Wellington. I have understood this explanation and have had the opportunity to ask questions and have them answered to my satisfaction. I understand that my participation in an interview is voluntary and that I may withdraw my involvement (or any information I have provided) without any repercussions at any point until the analysis of the interview data commences.

I understand that the information I provide, and the audiotape of the interview, will be kept confidential to the interviewer and the supervisor. I also understand that any written information related to this project would not identify me. At the end of the project, I understand that the audiotape will be securely stored for five years then wiped electronically. Any other use of the audiotape or information in it would require my separate permission.

I understand that the Victoria University of Wellington Human Ethics Committee has approved this study.

I agree to be interviewed for this oral history project.

Signed.....

I would like to be given my own copy of the audiotape.

Signed.....

Name of participant Date:

Name of researcher Date:

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