A 2022 Personal Retrospective of Children's Nursing 1970s – 1980s:

Wellington Hospital's Ward 19 Paediatric Ward and Beyond

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A Career in Children's nursing

At the beginning of 1970 I moved to Wellington to work at Wellington Hospital (WH) and start part-time study at Victoria University (VUW). After nurse training at Palmerston North Hospital, followed by 18 months of overseas travel and private nursing, and a few months working in Hastings Memorial Hospital, I had decided my nursing future would be in the paediatric field and was appointed as a staff nurse in the WH children's medical ward for the under-fives, Ward 19. I left my Hawkes Bay family home, and in Wellington joined a flat with my former school friend, Diana Bridge (later Schmid), a WH-trained nurse soon to become the ward sister of Ward 22. This connection with a friend eased my admission into the close community of Wellington Hospital. In retrospect, it was a sort of small village where staff and patients became the residents, visitors guests, and everyone knew their place in the scheme of things; it operated as a self-contained world where those of us coming in stepped from our out-of-work world and learned to fit and feel comfortable 'at home'. The paediatric hospital was an enclave.

During 1971 I was recruited to the WH School of Nursing to become a tutor. In 1972 WH sponsored me to do the academic year of study in the nursing education stream at the national School of Advanced Nursing Studies, to earn the Diploma in Nursing. Later I had a year's leave, 1974, to be an au pair with a young family in the NZ diplomatic corps in Paris. At the end of 1975 I left the employ of Wellington Hospital to take a position in the entry-to-nursing education programme being piloted at Wellington Polytechnic (WP). Here I established the paediatric nursing component of the Maternal and Child Health section of the Diploma in Nursing programme preparing students for registration. In 1979, with Eve Brister, I planned and set up the one-year post-registration Advanced Diploma in Nursing programme (ADN). This was NZ's first post-basic Maternal and Child Health course, opening the path for specialist careers in midwifery or the nursing of children. Teaching at WP I continued my connection with WH, negotiating clinical experience for nursing students in the paediatric wards to match the theory component of my courses at pre- and later, post-registration levels.

In 1986 my direct involvement with WH ended. Continuing to ride the wave of liberation of nursing education (from hospital training), I was appointed to the faculty of the inaugural Department of Nursing Studies at VUW; university degree study was opening for registered nurses in anticipation of broadly educated nurses taking leadership roles in nursing and the health sector. But then my connection with WH, particularly the paediatric wards, continued indirectly as site visits, which I needed to 'keep up with the play' and later to access families with hospitalised children as subjects for my research projects. My thesis for my Master of Science degree (Nursing and Family Social Science) at the University of Minnesota (1993) was written from my research involving the families of repeatedly hospitalised Ward 19 patients. My subsequent research for a doctoral degree thesis elaborated "Family Health" as nursing practice (1997).

The following is what I remember of my time of involvement with the children's wards of Wellington Hospital. In writing this paper now (2022) I inevitably mused on the changing socio-political context of family life and living in the 1970s and ‘80s, which brought into question the traditional management of paediatric care: the involvement of parents during hospitalisation and the practise of nursing in hospital and beyond. Contemporary social forces for change were represented in a complex web of relationships and knowledge development reaching around the world, and this drew me in. As context it shaped my career path in nursing education and research with the practice focus as family health and healthcare for children and families.

Ward 19: The Wellington Hospital children’s medical ward for the under-fives

Ward 19 and the other two children’s wards (18 & 20) were in the original Edward VII brick annex of WH. Sister Whelan was the Ward Sister: a calm, knowing, attractive, impressively organised nurse of indeterminate age. While very economical with words she radiated the authoritative air of someone confidently in charge - and she was very much in charge. Her glance was enough for us (all staff) to rethink what she had just seen us do, or heard us say. Before long Jan Allen was employed into the new role of Ward Clerk, much needed and appreciated in the office to ease the growing demand for paper work associated with ward management. There were times of heightened tension but generally it was an orderly, secure place to work, albeit always needing a rush to ‘get through’.

As for all wards in the hospital, Ward 19 had a historically well-entrenched hierarchical staff structure to be employed into: student nurses at the bottom, staff nurses (SN: a Registered General and Obstetric Nurse, RGON), ward sister (one per ward), nursing supervisors who roved through several wards, Inservice Educator, and hospital Matron at the top. And then beyond the hospital in the Department of Health sat the Director of the Division of Nursing and her advisors/inspectors, historically ‘keeping the troops in order’ nationwide. I was appointed and welcomed to WH by Matron, Miss Hough, a motherly, warmly engaging nurse approaching retirement; she had her finger firmly on the pulse of nurse deployment hospital-wide, and explained the role I would take.

Nurses’ place in the nursing hierarchy was announced in the colour and style of the uniform, the number of stripes on the epaulettes, and the headwear (cap or veil). The level - mostly meaning length of employment – assumed the degree of skill learned for the tasks to be allocated. Registered Nurses wore the 5-star medal and name badge with surname and title designation (Staff Nurse or Sister). In Ward 19 Sister Whelan wore a blue uniform with a few white stripes on her shoulders. She wore a starched and precisely folded white veil that tidily held its shape and position on her head the whole day. In the ward the medical personnel all wore white coats. They had their own hierarchy from medical students at the bottom, to “house surgeons”, to registrars, up to the paediatricians (three at this time), with Professor Weston as the senior authority.

Knowing the hierarchies was important for the communication pathways. Sister Whelan was the intermediary between nurses and the paediatricians. I don’t remember ever discussing a child’s condition and care with a paediatrician, just occasionally reporting an observation when asked. As nurses we used first names only when talking with other nurses at a similar level of seniority, and certainly not with the medical consultants. These formalities faded outside the daytime working hours (evenings, nights and at weekends). At these times we did engage directly with the “on-call” doctors to describe a worrying change in a child’s condition, and be given treatment instructions. This was often on the phone, and in person if the doctors considered the nurse’s report warranted a visit. Phonecalls were made with considerable trepidation on our part as nurses. If we called in a doctor at night and he considered our judgement to be an over-reaction, there would be terse comments or irritated rebuke. There were more concerns when the on-call doctor did not know the ward and we had to provide what we considered the vital information. To ‘get it right’, was always the worry for both nurses and doctors. At these times I was acutely aware of my lack of knowledge and relevant language to explain why I had concerns about a child’s clinical condition.

As a new recruit to Ward 19 I was given a questionnaire that Sister Whelan had compiled, requiring my written answers. The questions were on what she considered to be the basic knowledge essential for all nurses working on her ward. One was to locate the emergency trolley and identify the equipment. The equipment was laid out on a stainless steel tray covered by a cotton cloth “guard”. In the hallway there were large metal oxygen cylinders strapped on trolleys. The daily rostered task list for nurses included an itemised check and regular re-sterilising of the equipment, signed off in a notebook by the most senior nurse before we left the ward at the end of a shift. There was a “procedure book” - a ring-binder with consistently up-dated pages - in the ward office where we could search for detailed instructions on allotted tasks. But mostly I learned what was to be done, in the moment, through asking and watching my co-workers. There wasn’t time for anything else: there could be over 60 babies and toddlers as patients in the peak season for respiratory problems or gastro-enteritis. Sister Whelan kept an alert watch over the activity in the whole ward. It was terribly embarrassing to have one’s ignorance, naïveté or a too-rushed procedure exposed. This was inevitable from time to time, but it wasn’t a punitive environment; we learned fast not to repeat slip-ups. Reward was duty sign-off on time. And frequently parents brought in a box of chocolates for us as their gratitude - and relief - when they took their child home.

The schedule for the day/week/month was set. Nursing activities were organised around the routine “doctors’ rounds”), and the medical procedures of the treatment regime. When asked, nurses set up the appropriate equipment (this was what we were expected to know) and were available any time to assist in medical procedures. This made for a quick, efficient visit of the doctor to the ward.

Each paediatrician made his round once a week, methodically in a circuit of the ward, surrounded by his medical retinue of house surgeons and students; also Sister Whelan or her senior nurse deputy, and perhaps some para-medical therapists. Sister Whelan was director of the big heavy wooden trolley pulled out of the office (it only just fitted through the office door) that was the filing system for patient notes. They were open files slotted into the frame. And there were packets of x-rays, test results and wads of “old notes” of previous admissions.

It was expected that the children would be bathed and readied in their cots/beds quietly waiting. Play was on hold for all the children. We kept an eye on the round from afar, and when the retinue moved on we could step in to re-clothe and pick up the bewildered child. The “clinical team” completely surrounded the cot/bed, enveloping it and the child in it, while their professional deliberations and teaching went to and fro well above. Once I watched a small child purposefully slip off the bed between the white coats, quite unnoticed, crawl between the array of ankles and retreat to the end of the ward. In due course when the child was wanted for examination, someone asked where he was.

Visiting times for parents were restricted to two hours in the afternoons and a brief time in the evening, no siblings. The rationale for limiting parent visiting was the need for quiet, uninterrupted time for the medical rounds, schedules of clinical investigations and treatments, and to ensure regular rest periods for the children. It was a firmly held belief that, without mothers, the children were less distressed and obstreperous, the ward was quieter and more orderly, and therefore the rounds and procedures would allow for unimpeded observation and engagement with the patient, and therefore greater accuracy and quicker: “better for everyone”.

As nursing staff we were always acutely aware of our over-riding obligation to meet the expectations of an ordered and safe ward environment that would not impede the success of medical intervention. The big swing doors at the ward entrance were heavy to push open; they kept the children in and visitors out. They were closed after lunch for rest time. Ahead of afternoon visiting, parents sat waiting on long wooden pews along the blank wall of the hospital corridor outside the ward doors. It was on the dot of 2pm that the doors were somewhat ceremoniously opened to let them in. One of my most dreaded tasks was insisting that parents must leave their child when the official visiting time was over, and managing (as best I could) the harrowing distress of the children and emotional mothers at the parting.

Our nursing notes written in the “ward report” at the end of the “duty” (shift) allowed for recording our incidental observations of a child’s emotional state and meaningful behaviours as well as changes in medical condition, but the writing ritual was pared down to the minimum, the language was telegraphic, objective and standardised, and therefore the reporting mostly obscured the nuances of our personalised observations. The focus was the clinical status, physical aspects: the record of the treatment regime. This was the information essential for the nurses of the next shift to carry out their tasks and maintain some consistency in the care. There was an overlap of shifts of 10 minutes to provide for an informal oral handover, and it was here that much of what nurses knew about the children individually was shared. Of course a busy day meant less time for reflection on the happenings and discussion of what would be needed as personalised care.

I absorbed the rituals of ward operation as quickly as I could, to fit in and be accepted. They were not like anywhere else I had worked. The standard protocols and schedules for the ways of doing things for ‘small-size’ pathologies and treatment procedures were set. But I quickly realised that when it came to managing the behaviour of the children experiencing them I was totally unprepared. I did not know how best to manage their disparate reactions to treatments, to judge the pain and discomfort when they couldn’t tell us, to help them get through the procedures that could be distressingly invasive, intimate yet done to them by strangers without a parent for trust, to interpret, soothe and comfort. My previous experience of engaging with little children, that I could draw on for confident ‘common sense’ was very limited: my own childhood as the youngest sibling and a few weeks as a junior student nurse just doing allotted (mostly domestic) tasks. I cannot recall my nurse training programme going beyond this. Certainly, a caring, compassionate, trustworthy comportment was instilled in us from the outset. But the theory presented in classroom lectures and demonstrations related to the pathologies and medical treatments, simplified as the background needed to understand the principles of the ordered tasks we would be expected to perform. And this time in school was not aligned with ward placement anyway.

How to engage with the emotional parents was just as unsubstantiated and inconsistent, and it was dependent on how busy the ward was. I don’t remember thinking they were even part of the care we were providing for hospitalized children; just visitors. I do remember realizing how anxious the parents were, bringing their sick child into the stark unknown clinical context of the hospital, sitting through the formalities of the “admission” procedure, and then leaving them with the stranger-nurses and little idea of what the child might experience. They were expected to trust the nurses implicitly. For nurses, I think it was generally assumed that the nursing management of fractious children and confronting parental behaviour was common sense and compassionate instinct. It was expected that nurses would learn the specifics of hospital care for little children through practical experience, in situ as the approved ward conventions. There was a considerable degree of trial-and-error.

Commonly we saw our nursing role as ‘in loco parentis’ and were genuinely sympathetic and caring in the best way we knew - albeit culturally naïve at that time. Some nurses became strongly attached to one or other of the long-term patients as if their surrogate mother. Sister Whelan did not approve of what she saw as forming a dependency relationship that was, inappropriately, more of a mothering role than the professional one required for the clinical support role. Besides, the consistency of mothering was not feasible while children were kept in hospital for an extended period of time. Much later when I investigated how the rostering of nurses might provide greater consistency and trust in a nurse's relationship with a child, I calculated the minimum number of nurses any one toddler could engage with meaningfully, to develop the trusting familiarity that might lessen the fear and anxiety of separation from mother, was five over one week. And actually this was impossible in the ward management model.

There were sighs of exasperation from staff when a child was re-hospitalised yet again: readmitted having been discharged not long before, successfully treated we believed. These were "regular" families. And there were some children who were long-stayers: those with conditions difficult to diagnose, symptoms not responding to treatment as expected, or whose family we thought would be unable to follow discharge instructions at home. But we knew almost nothing of the lives of these families beyond the hospital so it was inevitable that judgements of child-rearing and possible determinants of the child's disease and hospital admission that they might go home to, were at times misguided and unfairly critical of the parents. As nurses we came to work in the ward from our different family backgrounds with our own ideas of upbringing etiquette and rules of acceptable behaviour; we came from different eras/generations of health ideas. Often I was unsure whether I had communicated at all with children or their parents, or what they understood. We only saw the parents during visiting hours and at these times clinical care for the child paused and staff withdrew and got on with other ward tasks. Anyway, we had not had tuition for 'assessing'. The steps of 'The Nursing Process' involving structured 'assessment' and 'care planning' were soon to appear in nursing education, but it was to be many years before 'cultural safety' was addressed.

We were proud to discharge a child to happy parents, treatment successful. The acute episode was over and our role ended. There could be written referrals to the District Nursing Service for a nurse to visit the home if some treatment procedure required continuing nursing expertise. The District Nurses might or might not have had some hospital experience of nursing children, while as ward nurses our experience of home visiting had been a very brief rotation in our training. However we had learned that the two settings required quite different ways of engaging with patients. I don't remember staff nurses from each service discussing the child's hospitalisation experience. The nursing provided was under separate management; hospital and home were quite separate worlds.

The gulf between the practices required of nurses in different settings was a key concern that drove my later research projects where I explored the nurse roles and service delivery model to address the fragmentation of care.

Some Points of interest in 1970s WH Children's Wards

An Exceptional Nursing Service

There was an exceptional integrative service innovation of the 1970s. Mrs Shirley Smith was a long-experienced registered nurse who had chosen to focus her career on the care of "children with physical disabilities" as part of the District Nursing Service of Wellington Hospital. Positions for specialist nurses had not yet been established at this time, but children were referred to her from medical clinics and the hospital because she had earned respect for her approach. Her uniquely personal approach was focused on the family predicaments wherever issues arose for them; she was readily accessible, was on first name terms with staff at all levels as with the families, and did not wear a uniform.

She initiated the outpatient Spina Bifida Clinic. This clinic brought together, in the outpatient department, the consultants from the diverse medical and surgical specialties, many other professional practitioners including social workers and school teachers, people designing and fitting items of equipment: that is, anyone involved in the management of the multiple challenges of any one child, often involving every system of the body.

Previously these children had required repeated hospitalisations from birth and attendance at the many quite separate specialist clinics. The nursing needed was complicated and continuously changing as children grew and family had to adjust. Shirley saw these families struggling and frustrated trying to work out how to have a family life when their parenting, their management of the prescribed medical regimes, and the schedules of social and educational support for one child involved such complexity. Times in Ward 19 had been a major and disruptive part of family life. There could be no doubt that Shirley Smith's clinics reduced the times and duration of hospitalisation; the children were no longer those patients we readmitted as well-known "regular patients" for yet another bout of treatment.

Shirley organised and orchestrated the clinic monthly, on a Saturday morning when it was possible to get everyone together - out of hours for the specialists. I remember the intensive flurry of effort in the ward office to prepare for the clinic, compiling the weighty "notes" and test results for each family from all the hospital and outpatient specialty departments. And this was just one part of the task of orchestrating the event: briefing everyone, ensuring appropriate access, coordinating the flow of appointments, and privacy on the day. At the clinic the event was an inclusive multidisciplinary consultation for the family, personalized. The various specialists discussed their diverse treatment proposals with each other and the family. Here the disruption of hospitalisation, and the disjunction of intensive clinical intervention and family life at home were avoided. The families were so grateful and all those participating actually enjoyed the event: there was a palpable spirit of elation and fulfillment afterwards.

This refocusing of management of healthcare to the complexity of the clinical predicament of a child in the whole context of the family's present and future circumstance was inspiration for my later trajectory of research. It was a demonstration of what was possible when nurses take a child/family-centred approach to healthcare

The Paediatric Ward wall tiles

To walk into the old brick children's wards of the Edward VII Memorial Hospital, was to be immediately impressed by the large framed sets of hand-painted porcelain tiles depicting traditional English nursery rhymes around the walls. The figures in them were larger than life size: people dressed in smocks, bonnets and bloomers going about the traditions of the village life in 19th century English rural landscapes, and the wording in the language and rhythm of that era. The frames imposingly filled the wall sections between the windows of the big open main ward, towering over the cots and beds placed around the perimeter. I remember (in the 1970s) trying to distract the attention of distressed little child patients (a large proportion from immigrant families) by talking about the pictures, and realising how foreign they were for them: the strangeness of a distant and past world.

One of the hospitals I was taken to on my tour of children's wards in London in 1974 was St Thomas', a hospital very proud of its nursing history with Florence Nightingale. Here I was amazed and delighted to find the familiar framed tile sets on the walls of their paediatric wards – and now in their cultural context. I made the mistake of exclaiming that they had the same tiles we had in Wellington Hospital in NZ. With noticeable indignation my guide told me they were prestigious Royal Doulton, antique, valuable and extremely precious historically, and painted especially for St Thomas' hospital.

We now know the tile sets were commissioned from prestigious Royal Doulton, to be built into the walls of our children's hospital named as a memorial to King Edward VII (opened 1912). And there were other sets sent to South Africa as well as elsewhere in England. Their value and history in NZ had been lost to those of us who cared for the children under their watch. On my return to WH, I was keen to pass on my discovery. When the replacement children's hospital was being furnished (opened 1988) there was concern for wall decoration in the wards that would be more currently recognizable for the child patients. I remember the anxiety about preserving them and the major effort that went into removing them safely from their fixtures in the wards. And there was excitement and pride in their new installation in the walls of other parts of WH.

The royal visit

In 1970 the royal tour of Queen Elizabeth II and Prince Philip had Ward 19 on their itinerary. There was great excitement. It was of such moment that the ward schedule for the day (usually so strictly defining time) was rearranged. It was my day off but I was not going to miss out on the opportunity to actually meet Queen. There was a full staff turnout, crowding the ward. Dressed in our most pristine uniforms - no stains or crumples - and caps carefully perched, we formed a ring around the main part of the ward. Nurses and other non-medical staff each held a child: one child per staff member. The children's gowns and nappies were only those most recently purchased, not the thin, stained, hospital-laundered ones with a tie missing. Balloons and flags were handed out, intended for the children to hold and wave. But I remember they were so stunned by all the palaver, it was the staff who held them, feeling ridiculous.

The royal couple arrived with the parade of senior medical and administrative staff, also dressed in their immaculately ironed white coats over suits and ties. The Queen was ushered around, stopping here and there to ask Dr Weston "what is wrong with the child?" and "is this (disease) common here?" (confidentiality not an issue). One little boy had stayed in his cot. The Queen paused to say hello and he tearfully asked her if she had seen his mummy coming. She answered him directly: "No, but I'm sure she's on her way". The Duke split off from the official clinical group and had an animated conversation with a group of thrilled nurses - lots of laughter. It was all over in a very short time. Then the ward took a breath while the enamoured "extras" left and the day's schedule rebooted.

The wider context of children's nursing

Through the 1970s, pressures were mounting for change in the hospital nursing of children and management of children's wards, coming from many directions. There were general social movements associated with public activism influencing social policy concerning family life and welfare. Within the health service system, advancing medical science and the technologies required more-appropriately qualified staff and greater effectiveness and efficiency in management and administration. More attention to health promotion and disease prevention turned attention to primary health care.

Woven into these movements was the major shift of nursing education from hospital apprenticeship schools (Health sector budget) into the tertiary education sector (Education sector budget), launched as a pilot in 1973. Wellington Hospital (WH) was entwined in this shift as the setting for the necessary clinical experience. Wellington Polytechnic (WP) was one of the three pilot Schools of Nursing for entry-to-practice; Victoria University of Wellington (VUW) inaugurated one of the two degree-based suites of courses for registered nurses to prepare for leadership roles. The traditional way of organising nursing hospital-wide, where trainee nurses provided a substantial proportion of the "manpower" needed for hospital operation, lapsed and the nurse hierarchy began its collapse into new workforce management support structures; the hospital's nurse training school began its slide into redundancy, and closure over the next few years.

This shift in conceptualizing nurse education was the culmination of half a century of drive by those nurses envisaging nursing as a distinct profession "in its own right". The enduring vision was that nurses would, as students alongside all other tertiary students, develop a comprehensive theoretical foundation for their nursing as a knowledgeable practice; they would be able to respond directly as professional practitioners to people's varied and changing health needs, whether physical or mental, and include health promotion and disease prevention - whatever the service setting (hospital or community) they chose to work in. These driving nurses, highly educated themselves, believed nursing education would at last be liberated from the restraining pressures of the employers (ultimately the Department of Health) influencing what should be taught to meet their staffing requirements with nurses as task-oriented "handmaidens". Rather, the new Registered Comprehensive Nurses would be free to nurse: a professional practice independent of, while complementary to, the practices of other professionals. This was part of the intensifying international thrust of nurses to advance education and professional status: nursing was a mainly women's profession in search of itself. The shift in NZ was, of course, only academic, and the reality fraught with tensions.

Discussing what the substantive content of what the novel education programme should be was the exciting – quite intoxicating - challenge for those nurses who, like me, chose to be educators. I was well aware of the need to advance my own education to understand health and nursing in contemporary New Zealand, as well as the international context.

In the 1970s, research and scholarship were flourishing in universities around the world, and schools of nursing proliferated in the academic world. Here was a substantial theoretical resource for rethinking nursing: its health purpose, knowledge and ways of practising. Beyond nursing, new knowledge from the research focused and fuelled public activism intent on disrupting current practices and instituting change to improve people's lives. The Women's Liberation Movement was strengthening and this was of particular relevance to nursing striving to be a profession. Childbirth and motherhood and what these meant for the lives and status of women in society were issues of public debate; specific attention to childhood followed a little later. In this, the status and roles of nurses, mainly women, in relation to the medical profession, mainly male-dominated, were up for challenge – but only in the academic fields: in the clinical world, the long-established relationships and misunderstandings between them made innovation hard going. Thus was the confused context for forging the new nursing education.

Through my formal tertiary studies starting in the 1970s, I discovered the wealth of new research findings, publications and animated international discussion and critique. Theories of child growth and development, particularly social-emotional aspects, were beginning topics of interest to me as I set out to understand the "normal", and what happened at home that might influence how we managed child hospitalisation and discharge. I could see that a theoretical base for the nursing of children would open practice possibilities that could mitigate the harms of hospitalisation and enhance the benefits from the advances in medical regimes and technologies. But I needed to look more broadly to develop a contemporary understanding of nursing.

My subsequent undergraduate studies spanned the Arts and Science faculties at VUW, and included the new Nursing Studies suite of courses conducted by Bee Salmon (who had been the key driver substantiating the shift in nursing education). Written for the course Nursing in Contemporary Society, the assigned essay "What is health?" (which took me the whole academic year to write) was particularly influential in my career: it was the realization that 'health' is a social construct and can have different meanings that opened my thinking. Whereas the current convention assumed health (and wellbeing) as the outcome of services, the meaning of 'health' as a process evolving lifelong had particular relevance for addressing 'family health' as the nursing endeavour.

The following traces threads of the web of connections and relations that was the social context for contemporary nursing and provided for me the backdrop for developing the new education programmes for the nursing of children and families.

As the decade of the 1970s opened, the findings of research from London's Tavistock Institute of Human Relations were reaching NZ academia. Tavistock is a research institute applying social science to contemporary issues. There, research associates James and Joyce Robertson had elaborated John Bowlby's earlier research into what he saw to be the essential nature of attachment between mother and infant ("bonding", in humans as for animals) and the foundation for normal child growth and development in all its aspects. The Robertsons were invited to New Zealand for a lecture tour. They presented their movies that emotively illustrated their focal research project: the intense anxiety that was the psychological impact of separating young children from their mothers, depriving them of the natural continuity of a loving, trusted relationship (eg "A Two-year-old Goes to Hospital", 1953). Scottish psychiatrist R.D. Laing was also connected to Tavistock. His published observations and internationally influential theory - albeit very controversial - took the thesis further into the medical field: the early disruption of the mother-infant bond, he argued, had clinical consequences of long-term psychiatric conditions.

In England the Tavistock research encouraged a group of worried mothers who had formed (1959/1960) the *National Association for the Welfare of Children in Hospital* (NAWCH, and later *Action for Sick Children*). Their active lobbying was aimed at changing the whole etiquette of children's wards, particularly the rules and regulations concerning parent visiting, provision for play and schooling, and generally a more child-friendly ward. But most important to them, was revision of the education of doctors and nurses to take account of the research findings. The movement spread internationally.

In New Zealand this activism attracted the attention of a group of mothers already active in the Parents' Centre organisation (fostering mother-child relationship). Helen Brew, who had inaugurated the forerunner of the Parents' Centre organisation, the Natural Childbirth Group in Christchurch in 1952, became the stalwart and vital campaigner on issues around the hospital practices for childbirth and childcare, midwifery, and included the issue child hospitalization. The mothers were convinced by the assertion that disturbance of the mothering bond could have harmful long-term adverse consequences. Settling in Wellington, Helen Brew pursued with great zeal the mother-infant theme through making documentaries to substantiate mother-child bonding as a universal and essential phenomenon. For two of these documentaries she convinced the by-now internationally renowned R.D. Laing to collaborate with her. One was screened in many countries in 1977 as "Birth with RD Laing", and in NZ on prime-time national TV. The TV showing brought awareness and critical attention to the issues of mothering, and hence, for many of us, to the separation of children from parents through hospitalisation.

In Wellington, the NAWCH activist purpose and achievements inspired the formation of the *Committee for Children in Separation.* It was a small unstructured group, named to convey that its focus was wider than that of the NAWCH hospitalization focus. However, members held meetings in Wellington Hospital and lobbied for changes in children's ward protocols that would free up parent involvement and improve communication between parents and staff: nurses, paediatricians, ward staff, hospital administrators. I attended these meetings, and a few of the ward nursing staff did too, but only briefly, probably because the mothers' criticisms of the hospital practices were explicit and emotional. Practising nurses were anxious that the public (including these mothers) did not understand why the restrictions limiting parent involvement were necessary for what they (nurses and doctors) believed to be in the best interests of sick children: that is, to avoid the distractions created with visitors in the ward and to offer the best chance for the intensive medical intervention required to be effective and efficient.

Some nurses recognized the relevance of children-in-separation movement for developing nursing education. Alice Fieldhouse had become an early, committed and active proponent in the Parent Centre movement in Wellington, and in the 1970s she was involved alongside Helen Brew in activities of groups concerned with addressing social issues of motherhood, women's equality and parenting. She was a highly educated nurse, recognized in the nursing world for her earlier substantial work on the updating of the curriculum design for hospital schools, and she argued the need for nurse tutors to have academic (university) qualifications. In 1972 she was leading the stream for nurse tutors in the programme at the NZ School of Advanced Nursing Studies (SANS)[1] when I undertook the year of study for the national Diploma of Nursing. She was married to Professor Arthur Fieldhouse whose academic field was the child development thread of the VUW Department of Education. His course gave me the introduction to theories of mother-infant relationships and their significance for child development, and Alice Fieldhouse encouraged my family focus opening my eyes to the potential for developing the education for nurses to practice in new ways with a more theoretical foundation. The Fieldhouses together contributed significantly to the success of negotiations for the 1973 inauguration of the Nursing Studies unit at VUW as a section of its Department of Education.

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[1] SANS was funded by the Department of Health and the Diploma qualification and sanctioned by VUW. It was established in 1928 as the national preparation for leadership and teaching. Until 1973 it provided the only opportunity in NZ for registered nurses to study at tertiary educational level.

One of the criticisms of nurses coming from the lobbying groups of mothers was that if we did not have experience as parents we could not understand child and parent needs associated with hospitalisation. So in 1974 I was pleased to have the opportunity for a stint as an au pair with a young NZ diplomatic family in Paris (and I was excited to live in Paris). I took a year of leave from the WH School of Nursing. This travel overseas was also an opportunity for me, en route through London, to have a look at the hospital nursing of children and contemporary developments in nursing education. I arranged a meeting with Peg Belson, the driver of NAWCH that had inspired the establishment of the *Committee for Children in Separation* in NZ. She prepared a programme of visits to some London hospitals for me. When I arrived to start the tour I was surprised to find NZ activist Helen Brew joining me. On a Nuffield Fellowship, she too had contacted NAWCH: the NZ network of lobbyists fuelling change echoed the international movements.

I didn't see the innovation I was expecting in the London paediatric wards. But in one hospital, the paediatrician who had been appointed as our guide (not a nurse) explained that the medical staff had dispensed with their white coats to be less intimidating to the children. Yet the nurses were wearing traditional formal uniforms, which made their appearance seem more imposing and forbidding than ours in NZ. Echoing this initiative for more child-friendly children's wards, a trial was run some years later (1980s) for nurses to wear mufti. This change was eventually not supported and nurses returned to their uniforms. I recall the main objection to mufti, from the nurses, was that no one could tell who was who in the ward. A less-voiced concern was the suitability of the nurses' personal wardrobe needed for their often-messy work, and the laundering (uniforms were laundered by the hospital). However, over time the uniforms did become less clinical and more 'normal' for the children.

Shortly after my return to Wellington in 1975, the *Committee for Children in Separation* was one of the key drivers of a meeting (held at VUW) of various organizations and individuals concerned with issues of childhood. The outcome was the formation of a new, more extensively influential organisation: the *NZ Trust for the Foundations of Mental Health*. Helen Brew and Alice Fieldhouse were among those elected as founding trustees. As an attendee I was excited by the burst of energy of purpose: I could see how my efforts to develop family and children's nursing would be part of the social movement for a broadened more holistic context for innovation. The need for funds to advance the Trust's cause led to naming "Mental Health" as the theme for the TV Telethon in 1977, a 24-hour nationwide charitable fund-raising event, which would rouse a population mass to tune in to the issues. Through this funding boost, the Trust developed a structure and took its enduring form as the *Mental Health Foundation* (MHF).

The MHF acquired political lobbying weight. It seized the opportunity of UNESCO's (*United Nations Education, Scientific and Cultural Organisation*) declaration of 1979 as the *International Year of the Child (IYC)* to inform, urge and support the NZ Government in its planning for an ambitious policy-aimed programme for the year. The activities were widely inclusive of those concerned with childhood and growing up in NZ. 'Child Health' and 'Mental Health' were two of the twelve themes. Each of the IYC theme groups, chaired by a prominent personality, organised activities (one theme per month). Margaret Lythgoe, an eminent nurse leader (in NZ and internationally) and a close colleague of Alice Fieldhouse, chaired the Child Health theme group, so the issues of child hospitalisation, maternity care and nursing came to the fore.

At the end of the IYC, the *NZ Committee for Children IYC Inc.* (CFC) was formed to hold and channel its energy and continue to actualise the work and ideas generated. In 1984, nominated by the NZ Nurses' Association, I was voted a member of the CFC leadership group and saw it through to the organisation's closure at the end of its decade in 1988. One project I was particularly concerned with was a national conference on violence ***in*** children; the prominent leaders from the various academic fields, policy makers, professional services and parent groups came together. I had been disturbed by the aggression of some children in the hospital that I couldn't explain and had no way of addressing; it wasn't a relevant aspect of nursing there. But I knew it was a much wider social issue with life-long and widespread implications, and we needed to understand it better as an aspect of health and the care of children and families. Another CFC project was a study of Ministry of Transport records of school bus accidents which led to a proposal for policy on seatbelts (front seats at least) and other bus design modifications.

The CFC's closing document was a substantial submission presented to the Royal Commission on Social Policy (1988). Drawing on the decade of its work and the information amassed, the CFC recommended - urgently and strongly, and with reference to international developments - legislation to establish a dedicated position and supporting body that would advocate for children, funded by Government but independent. It was to be a "voice" for children: an influential thread of policy at the core of NZ government.

The following year the *Children, Young Persons and their Families Act (1989)* was passed establishing the position and office of the Commissioner for Children, independent politically while able to engage directly with the Prime Minister on children's issues. In 1990 the Office of the Commissioner for Children organised its first seminar *Toward a Child and Family Policy for New Zealand*. My presentation to this seminar, *"Health connects Children with our Future",* urged a holistic stance in healthcare policy. This meant a refocus of what is considered the vital foundation of child health: that is, the circumstances of family life with the complexity of health predicaments, including living with medical interventions and hospitalisation.

Major change in nursing education

It was these child and family-related movements of the 1970s and 80s - creating the networks I was drawn into - that gave me theoretical reference points for designing and orchestrating courses in the new nursing education programmes. The social-emotional thread of child development became pivotal. So the theoretical foundation for nursing children, whether in hospital, homes or communities, assumed the inclusion of parents, all whanau, as the focus of nursing practice: my education role took a 'family health' approach.

The arguments driving the shift in nursing education asserted that more knowledgeable nurses would question the status quo and influence change. Hence the reorientation of nursing practice to family life (rather than to service roles) was an alarming challenge to the traditions of management and organization of the children's wards and hospital care that were geared to order, stability and efficiency of service operation. For the practising nursing staff, the hierarchical line of authority, their status and career advancement, job security and pay were all seen to be under threat. Further, the sudden influx of Polytechnic students on clinical experience placements disrupted the routines. What theory there was to know (they the students might know) that was relevant to the practical expertise familiar to them was a mystery. The commonly heard comments were: "nursing is practical not theoretical", and "too much theory" (education) distracts from the performance required of nurses that can only be learned "at the bedside", "in the real world" of healthcare.

Hence, the new students of nursing naively intruded into the well-entrenched patterns of work expectations and relationships amongst nurses, doctors, child patients, their parents and families. They were on the faultline of traditional protocol-bound etiquette and the contemporary thrust from nursing education to introduce knowledgeably self-directing practitioners. There was misunderstanding, confusion and inconsistency around what “the Polytechs” should be allowed to do as students, what they should learn, and who should be supervising what. They didn’t know the traditions, while having knowledge for looking at and doing things differently. And they asked awkward questions. They often had a hard time as they felt their way trying to be accepted, to avoid conflict and fit in. They learned a lot (usefully for the future) about the issues of change in nursing and healthcare.

As a tutor, I trod this faultline, questioning and learning how to advance this unprecedented and still-debated approach to nursing education. It was often a resistive and emotive environment. I was grateful to have had experience as a staff nurse in the children’s wards so I was not entirely an alien. In my role I was protective of student learning while knowing the etiquette of the wards. Nonetheless I usually ‘walked on eggshells’ through the day. As well as education mentor for student learning, I was interpreter for both students and staff, and moderator between them to ease tensions, wanting new understanding on both sides. It was a testing time for everyone.

Into the 1980s, the designing and planning of the replacement WH Children’s Hospital provided the opportunity for hospital staff to take account of contemporary social movements and look afresh at how children should be cared for in hospitals. Particular attention went to the accommodation of parents. Parent visiting opened and other restrictions on parent involvement eased.

However, the old hard boundary between hospital and home that carved out discrete nurse roles was well embedded in tradition. And further, the stability of the old ethos for organizing nurses and managing nursing, although rocked by the changes of the 1970s and ‘80s, proved very robust: resilient and difficult to question. This was the challenge that set me on my trajectory of nursing research from the 1980s.

Heading into health system reform at Wellington Hospital

At the beginning of the 1970s the roller-coaster era of major health system reforms was approaching. As a staff nurse and tutor, like other nurses, I was as yet oblivious to the mounting clinical and socio-political pressures for restructuring to improve efficiency in the health system, and what the implications might be for nursing or our employment. Such topics were not seen as relevant to nurses in the old hierarchical structures and training system. I remember two projects alerting me at WH: introduction of computers and consultancy for management change.

We were hearing talk of computers associated with management developments. In WH, Ken Ward was appointed to a new position to consider the emerging technology and introduce it to the staff. I attended his series of lectures for all staff in 1970. I remember trying to grasp the idea and relevance of the precisely detailed and digital nature of computer programming and systems for documentation. As an illustrative exercise during one lecture, Ken had us break down the task of cleaning our teeth into the specific actions as components of a logical sequence. I could not imagine what the relevance was for nursing of such a laborious activity. Furthermore, like most of those attending, I couldn’t see there was any need for change from the way we were already doing things. Besides, nursing was personalized.

In 1972 WH contracted an international management consultant, Irishman Michael Gorman (PA Management Consultants Ltd), to observe and make recommendations on hospital management practices. From the papers written of his work, his purpose was “to get more from existing resources… to improve the value obtained for money spent in health services”. He addressed issues of staff relations: for nurses, this meant involvement of Ward Sisters in management decisions. One experienced Ward Sister, Barbara Mercer, who had just completed the year of study for a Diploma in Nursing in hospital management (SANS), was pulled from her chosen ward position by the matron to be appointed as his assistant. Her substantial institutional knowledge of nursing and its organisation was essential for planning developments of the hospital service, and appreciated. Very soon they married. As was common at the time, when nurses married and had children, her nursing expertise was thereafter lost from the hospital "manpower".

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Research, Projects and Publication

My concerns arising from my experience of Ward 19 in the 1970s-1980s, and the challenges these concerns posed for my role in the education for children's nursing focused my own university study and path of research. It began with the social and emotional implications of separating a hospitalised child from parents and the restrictions of parent visiting. Textbooks were appearing with reference to the "holistic" nature of nursing and the integration of "bio-psycho-social-emotional" threads of child growth and development. Meanwhile, the primary focus of the management of paediatric wards and the general deployment of the staff "manpower" was the physical/clinical treatment regime. And the hospital episode of medical intervention was quite separate and removed from the familiarity of home, mothering and family life.

From these beginning concerns my research interest broadened to child healthcare beyond and including hospitalization: taking a family-centred stance, the hospitalisation could be viewed as one event in the entire life and living of the family. This called for a fresh approach to nursing practice and research and the building of a theoretical foundation to substantiate change. Eventually, from what I learned through my various research projects, I realized it was the concept of whanau/family health as a whole that was needed: the circumstances of family life in which the complexity of child health predicaments, including hospitalisation, played out over lifetimes. It was a knowledgeable whanau/family nurse, mobile through the community, whose practice could provide an interface between all the service sectors and everyday living: wherever 'health' in the family is an issue. This was a novel idea at the time. The firmly historically-embedded assumptions of the health system structure divided the personal healthcare services into discrete 1°, 2° and 3° sectors, and these personal healthcare services were quite separate from public health programmes. My research projects then turned to re-conceptualising the model of service design and delivery introducing a few whanau/family nurses whose practice would create an integrative hub for accessibility to all services.

First, in 1973, as a tutor in the hospital school of nursing, I put my observations in the paediatric wards into a presentation for an in-service refresher study day for practising nurses. To focus analysis I asked some mothers of children then patients in Ward 19 what they did for their child in the ward and what they would like to do. The paper was published in the NZ nursing journal, December 1974 (Kai Tiaki, 67(11), 17-20): "The Paediatric Nurse - and a Child in Hospital". It was my first effort at research and it impressed on me the importance of research to bring insight and expand my own knowledge. This was the knowledge I needed to give direction to my teaching efforts, and eventually to give legitimacy to any proposal for changes. And it confirmed for me the trend I was reading in the international nursing literature at the time that claimed the rightful focus for knowledge development in nursing is the experience and predicaments of the people being nursed.

The mothers I questioned commonly said they did for their child whatever the nurse said they could; they would be very pleased to do anything for their child as long as they were not interfering in treatment activities or getting in the way of the busy nurses. I realised the power that we exerted as nurses, unaware, in controlling the hospital space and who engaged with whom; I realised how we assumed higher authority over every aspect of the daily care of the child. The fracture of mothering through hospitalisation was abrupt and confusing for mothers and children. Comparing themselves with the nurses who, to them, seemed so confident, mothers didn't feel they could or should do as they usually did to comfort and care for their child at home. They trusted the nurses to take over the hospital episode and do the best for their child.

Later in the 1970s I tried out the idea of an additional nurse role: picking up the healthcare of children during the hospitalisation event (in Ward 19) and moving with them through discharge and back into home life: a possible hospital outreach service. At the time the role of a District Nurse was, when referred at hospital discharge, to visit the home to provide the specific expertise that would maintain the medical treatment regime started in hospital. My questioning of mothers did not have the rigour of a formal research process but I awoke to many things about the disruption in family life and complexity of adjustment needed following a hospitalisation event, as well as to the challenging practicalities of ongoing interventions and surveillance outside the hospital. I realised the parents' need to have timely access to knowledgeable help, to understand the predicament and what was required of them to cope with issues as they arose. And I could see that the design of the existing service configuration did not allow for such a comprehensive approach for continuity of care.

These insights inspired my research trajectory. I began to recognise the need for nursing in a new way: nurses with a perspective and knowledge relevant for a family-oriented nursing practice and the reconfiguration of nurse roles needed to position and sustain this cross-sector practice. The research-based projects were undertaken in a variety of settings and produced a range of findings and recommendations. These projects included: a primary school-based nurse accessible for the whole-family as "the client" (1980); urban family-focused "Nurse Case Management" (1993) based in the physical disability service managed by Shirley Smith, a section of the District Nursing Service of Wellington Hospital (Department of Health funded to inform the approaching "Health Reforms"); an analysis of the need for a hospital outreach role of an advanced nurse practitioner in the WH's Mental Health Service (commissioned by Wellington DHB, 1994); a case study of rural healthcare as a nurse-community partnership, "Achieving Health in a Rural Community" (locally funded, 2004); the configuration of existing nurse roles for an comprehensive and integrative approach to rural nursing (Otago University Christchurch's Centre for Rural Health, 2004).

Meanwhile, through my theses submitted for Master of Science and PhD degrees at the University of Minnesota (part-time and commuting, 1986-1998), I completed a two-stage exploration and substantiation of the form of nursing practice I would propose with relevance for development in NZ. Through these studies my attention to concerns around hospital nursing broadened into a comprehensive family-oriented conceptualization of nursing practice and roles. In the first research I was concerned with the nursing of families with repeatedly hospitalized children. In the second I looked more broadly at the practise of nursing as a process of partnership with families living in complex health circumstances: nursing practice can be construed as the "process of family health". The research approach I developed was novel. With myself engaged as practitioner and researcher simultaneously, I could describe both the process (my part in it) and what eventuated for health and family life: "research-as-if-practice". It was a learning time for me. I had to explore the philosophy of science and contemporary meanings of research: to understand the nature, development and use of 'knowledge' that differentiates the practise of medicine and the practise of nursing to address the 'health' purpose in NZ.

It became increasingly obvious through these studies that what people wanted and needed, particularly when the medical management was complex, was someone who was knowledgeable about clinical matters (relatively simplified) while paying attention generally to how they were having to *live with* the pathologies and treatment regimes. They clearly came to understand how their health predicament had arisen and how they could get on with life and living as families and citizens into the future. It was the nurse's attention to the particular, personal, health circumstance, taking account of whatever the complexity in their daily lives in time and place, which enabled them to see a way ahead with peace of mind: how they could access relevant services and information and get greatest benefit from the medical treatments and technical aids. Central to this nursing practice was the nurse's recognition of the variability of lives of NZ people as families and citizens, and the non-prescriptive relational nature of engaging with them. Later projects showed how, from the family's perspective, the respective practices of nurses and doctors when considered different and complementary were mutually supportive in bringing longer-term benefits for health and lives. Considerable efficiencies for the health sector were presented. Questions arose about the education required for at least some nurses to develop this form of practice that is quite different from the focused clinical prescriptive purpose of medical practice.

Along the way I discovered it was not enough to present a reasoned argument for innovation in the practise of nursing if it could not be seen as improving – and supporting - existing beliefs, structures and funding flow. I could see I had to actually demonstrate and substantiate with more extensive real-time data what could be achieved by a new conceptualisation, in context, if it was to be taken seriously, both in the nursing world and in the wider health sector. The opportunity to do this arose when my proposal for a 3-year project was selected by the Ministry of Health as one of the 11 nursing projects (2003-2006) funded to inform the development of Primary Health Organisations. The project was of a whanau/family-pivotal healthcare model, with a few Whanau/Family Nurses appointed to develop practice in the novel role: it was "a practice and systemic approach" to integrative whanau/family-centred healthcare. The project was supported by Lakes District Health Board, hosted and its funding administered by Tuwharetoa Health Services Ltd in Turangi. The detailed report was submitted to the Ministry of Health. Positions for four whanau/family nurses to provide a healthcare hub for the new Lake Taupo PHO were briefly instituted. The idea struck a chord, was welcomed and spread. But what was needed for the innovation to develop as a model was shelved.

This took my career path from research projects to consultation and writing. The whanau/family-centred radial model was presented and has been cited variously in New Zealand and internationally. There were seminar contributions, meetings (including Ministry of Health) and booklets published to report the projects, and items in the nursing journal Kai Tiaki. A paper, "Health Connects Children with our Future", contributed to a multidisciplinary conference on child and family policy and published by NZ's Office of the Commissioner for Children (1991). The relevance of the concept and model for the era of competitive, market-driven health system reforms was an invited chapter, written with Wellington Hospital's Nurse Consultant Maureen Laws, in a US edited volume of nursing innovations titled "The Outcomes Mandate" (1999): "Achieving health and cost-containment outcomes in New Zealand". The potential impact of the nursing practice and its role in healthcare were cited in the monograph reporting a world-wide review of approaches to developing models for family nursing. This review was commissioned and published by the International Council of Nurses (ICN) to commend and substantiate its support of the WHO's agenda promoting a family health nurse role as key for future health service systems (ICN, 2001). Another invited chapter titled "A clinical and systemic approach to innovation in healthcare", was a contribution to a textbook of various internationally-authored ideas and developments of "Family Nursing in Action" (Kolbrun & Jónsdóttir, 2011).

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Through this trajectory of exploration of nursing, health and healthcare, I had seen how the hard boundaries dividing service sectors meant inefficient fragmentation of healthcare. For families this was a frustrating ‘pass the parcel’, costly and maybe unfulfilling experience; for service providers, it was confusing the deployment of workforce. I had come to understand that it was the entire healthcare system needing a shift in mindset: from the extant linear service organisation model (1°-2°-3°) to a radial people-pivotal healthcare model (hub and spokes). And I had found how just a few broadly knowledgeable nurses could be the catalyst for such a change, developing their practice stance to take a new role as an interface between everyday family life and services.

However, I realised that service design and delivery has been, over time, increasingly institutionally-bound and self-reinforcing - and resistant to innovation. This pointed to enduring challenges for everyone concerned with ‘doing better’ in providing healthcare. For nurses, the challenge posed was to further the potential shown to influence vital change when nursing practice reorients to health as a whanau/family matter and embedded in the circumstances of everyday living.