

Imperial sisters in Hong Kong: disease, conflict and nursing in the British Empire, 1880–1914

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British nurses, much like those enlisted in the colonial or military services, frequently circulated within the Empire as a professional necessity, often in response to the development of perceived crisis in the form of conflicts or disease outbreaks, prompting reciprocally shaping encounters between individuals within the various colonial outposts. More traditional approaches to the history of nursing are enclavist in the sense that they have argued that nursing practice, education and policy were established and consolidated in the metropole before being exported to the colonies by British nurses, and as a consequence, professional nursing developed independently in each of the colonial outposts. However, cases like that of ‘Nellie’ Gould illustrate that nursing practice was equally constituted on the peripheries, and that a complex network of nursing ideas existed within the British Empire, fuelled and enhanced by the mass migration of nurses between various colonial locations.

Ellen Julia Gould (known as Nellie) was a well-travelled woman. Born in the Monmouthshire town of Aberystwyth in 1860, she spent ten years of her youth studying languages in Portugal before returning to London and later working as a governess in Hamburg. After a family visit to New South Wales she began a two-year nurse training course in January 1885 at Sydney’s Royal Prince Albert Hospital, a shift in vocation resulting in the almost continual accumulation of professional accolades over the coming four decades. In February 1899, while she was matron of the Hospital for the Insane at Rydalmere, Colonel (Sir) William Williams sought her advice on the formation of an Army Nursing Service Reserve (ANSR) that was to be attached

to the New South Wales Army Medical Corps (NSWAMC). Three months later, Gould had amassed twenty-six nurses and assumed the post of lady superintendent. On 17 January 1900 she, along with thirteen nursing sisters, left Australia to participate in the Second Boer War (1899–1902), serving at hospitals in Sterkstroom, Kroonstad, Johannesburg and Ermelo, often beside Buller, the Rhodesian ridgeback that had become the adoptive mascot of the ANSR team. Upon returning to Australia, Gould, alongside fellow veteran Julia Bligh Johnston, founded the Ermelo Private Hospital in Sydney, and continued to work tirelessly towards the professionalisation and amelioration of both general and military nursing in Australia, the latter in her role as principal matron of the 2nd Military District. As part of this process she helped create the Australasian Trained Nurses Association (ATNA) in 1899, serving as a council member until her retirement in 1921 and instigating the publication of the association's journal in 1903. On 27 September 1914, shortly after the outbreak of the First World War, Gould joined the Australian Imperial force (AIF) as matron of the No. 2 Australian General Hospital (AGH). She and six other nurses arrived in Alexandria on 4 December, remaining there long enough to nurse casualties from the Battle of Gallipoli (from April 1915 to January 1916). She finally returned to Australia in 1919, after a stint on the Western Front and the award of a Royal Red Cross (1st Class) and was discharged from the AIF at the age of fifty-seven, at which point she retired from professional nursing.¹

Nellie Gould is remembered as a visionary and pioneer, prompting the often rather triumphalist and sanitised recording of her biographical details. She has frequently appeared in military and medical histories of both the Second Boer War and the First World War, and has been central to many commemorative endeavours, for example the Australian War Memorial's 2011 exhibition *Nurses: From Zululand to Afghanistan* and, most recently, ABC's celebratory TV miniseries *Anzac Girls* (2014). Like her colleagues in South Africa, Gould was unmarried (as were all nurses of her time) and dedicated to her profession, and early photographs are constructed depictions delineating her embodiment of idealised nursing qualities, including bravery, selfless commitment and education, qualities that were subsequently among those of the quintessential Australian combatant immortalised in the Hall of Memory at the Australian War Memorial. Her

perpetual association with the development of Antipodean nursing is understandable. She was trained in Australia, dedicated her professional life to the instigation and expansion of nursing infrastructures in New South Wales and her 'frontier experiences', her links to the 'old country' and her military experiences (particularly at Gallipoli), allow her to be easily assimilated within the early formation of notions surrounding Australian nationalism. More specifically, her encounters have rendered her an integral part of the feminised reshaping of the Anzac Legend, the controversial and evolving cultural concept founded partially upon the apparent personal qualities of the romanticised Antipodean soldier.² Consequently, it might be argued that her professional sense of self-identity was decidedly local.

However, despite being claimed as Australian as part of a process of patriotic redefinition and the resultant need for domestic cultural icons, a process that was largely posthumous in her case, Nellie Gould was a true product of empire. Her origins were British, her training Australian, and much of her experience gathered in the European metropolises and their colonial outposts. The knowledge she gained as a result was utilised to help expand and reshape professional infrastructures in her adoptive homeland. To remember her predominantly in an Australian setting, or within the confines of histories exploring the Second Boer War or the First World War, disregards the formative impact of Gould's colonial experiences and is indicative of the enclavist, overly descriptive and somewhat atheoretical tendencies that have predominated a great deal of nursing history in preceding decades.³ Her encounters, and their professional and personal resonances, transcend national borders and the chronological boundaries of the conflicts she is most frequently associated with. These experiences and their influences were transnational, and they should be considered, like those of many of her fellow sisters, particularly those in colonial or military service, within the context of what Tony Ballantyne has labelled 'webs of empire'; cultural and economic networks which connected colonial outposts to other locations, thus creating mutually influential relationships aided by technological developments, for example the expansion of print culture.⁴ The recognition of such networks allows the internationalisation of colonial history and challenges previous suppositions regarding the interaction between metropole and colonies.

This approach is not designed to perpetuate assumptions surrounding the 'global' as an analytical and descriptive category, nor yield to what Warwick Anderson has labelled 'the hydraulic turn'.⁵ It does not assert that a universal, identically replicable 'placelessness' existed in nursing education and practice. Instead, the intention is to look precisely at the individuals, institutions, ideas and events that connect these places, while at the same time recognising the impact inherent differences between locations had on the development of the nursing profession. The examination of specific sites is productive as it allows the influence of their interconnected nature to be recognised, as well as facilitating the equally revealing exploration and comparison of their differences, comparisons which often prompt interesting further questions surrounding race, gender and professional relationships within medical infrastructures and among the wider populace.⁶

While distinguished, Gould's experiences as a nurse are indicative of broader trends rather than mere idiosyncrasies. Sister Brenda Marie Hoare, born of Irish aristocracy in Ceylon, trained at St Thomas' Hospital in London before working at Bloemfontein during the Second Boer War and later returning to the Indian subcontinent in 1903 as Lady Superintendent of the Afzalgunj Hospital at Hyderabad. Marianne Rawson, one of only three Australian women to be awarded a Royal Red Cross (1st Class) during the Second Boer War, received her education in the UK and Ireland, experiences that would, collectively, lead the Governor-General's wife to seek her advice on the establishment of the organisation that would later become the Australian Red Cross. Some, like Miss Eastmond, the first matron of the Government Civil Hospital in Hong Kong, would return repeatedly to the same location to complete numerous tours of service.⁷ Others utilised their overseas experiences to help leverage promotions at home and in different outposts. Sister Helen Batchelor, for example, used her training from The London Hospital to gain a post at the Government Civil Hospital in Hong Kong in 1898, and five years later she appears as the newly appointed matron of the Government Civil Hospital in Mauritius.⁸

The pages of professional journals from the age, including the *Nursing Record/British Journal of Nursing*, are replete with similar overseas opportunities and appointments from all areas of the British Empire, allowing nurses at various stages of their careers to exploit

the professional networks contained within. The use of biographical fragments, like those of Nellie Gould and her colleagues that appear within these journals, as well as other contemporary textual sources, enrich evidence offered by more conventional representations of nursing. This allows, as Clare Anderson, Alan Lester and David Lambert have demonstrated, a fresh interpretation of the character and significance of 'networked empire' and supports a restatement of the importance of individual agency to the development of the type of administrative systems and reformative undertakings that often arose in response to societally disruptive events like disease outbreaks or wars.⁹ The evident movement of nurses within the Empire was not characterised by seamless 'flows' of capital, trends or ideas. The implementation of British nursing practice and education varied between outposts, was facilitated by the conscious, strategic choices made by career-minded individuals, and was often a point of contestation for colonial authorities that only the bigger danger of a perceived crisis could help assuage.

Crisis as a lens

The prevalence of existing medical histories exploring the development of nursing during the Second Boer War or the First World War means that the decades between 1880 and 1914 remain largely neglected despite being crucial to the institutional expansion of nursing in the British Empire. The period witnessed many of the numerous expected markers of professional standardisation and stratification on an international level. These included the formation of the first nursing schools in dozens of colonial outposts, the first registration and national regulation of nurses in the Cape Colony and New Zealand respectively, the foundation of the International Council of Nurses and the Colonial Nursing Service, the addition of a nursing corps to the military medical services of numerous countries and the growth of the International Committee of the Red Cross.¹⁰ Such developments were the result of years of collective effort and again indicate that the expansion of nursing practice transcends the selective geographical and chronological focus of many existing histories.

The period was also characterised by instances of global crisis, which provide an important context for reappraising the history of nursing at a local, national and transcontinental level, as well as acting, at least in part, as a catalyst for many of the operational changes listed above. Perceived crisis, as exemplified by the Second Boer War and outbreak of what was later referred to as the third plague pandemic, exist as disruptive events and reveal underlying and often invisible social, economic and political processes. The period between 1880 and 1914 encompassed various other examples of perceived crisis in which nurses played a vital role. Aya Takahashi, for example, has written eloquently about the transformative function of Japanese nurses during the Russo-Japanese war (1904/5), particularly their encounters with enemy wounded and their part in the adoption of innovative triage procedures. Such events, while able to command the attention of the international medical community, were not necessarily recognised as 'global' in their outcomes or impact.¹¹

As Charles Rosenberg demonstrated in his work on cholera in America, crisis functions as a sampling technique as well as a subject, creating a stimulus and contrast, and thus allowing an assessment of the reactions and social changes prompted by the event.¹² However, despite describing a compelling paradigm Rosenberg ignores the fact that wars are equally revealing as opportunities to examine societal change. In the late nineteenth and early twentieth century warfare was often prompted or prolonged by similar developments in disease outbreaks, including expanding transport networks, economic competition between nations and technological advancements. Reactions to such events were often shaped by numerous influences. The individual character of different locations of crisis, its racial and socio-economic composition, administrative structure and geography all played their part; and comparisons between such sites expose municipal deficiencies, assigned culpability and administrative solutions that were often strikingly similar.

Case study: plague in Hong Kong

Carol Benedict argues that the outbreak later referred to globally as the third plague pandemic probably originated in the Chinese

province of Yunnan in the 1850s. Intermittent rebellions against the Qing court, and a lucrative trade in opium and tin, provided corridors for inland disease reservoirs to coastal ports such as Guangdong, Guangxi and Guangzhou. This process is likely to have been further aided by the growing opium trade between Yunnan and coastal cities such as Beihai, a focal point on both the Red River and You Jiang trade routes. Plague probably first entered Hong Kong via Beihai, where it had been present since 1867, although it was only when the junk boats travelling between the two ports were replaced by steamships in the 1880s, making travel faster and more convenient, that the likelihood of transmission was greatly increased. From its arrival in Hong Kong in 1894, the disease spread internationally, as well as to other ports along the Chinese coast, including Xiamen, Shantou and Fuzhou. While precise figures remain contested, Myron Echenberg estimates that the third plague pandemic claimed 15 million lives globally between 1894 and 1950.¹³

While the financial and demographic impact of the plague across the Empire remains questionable, a general consensus has emerged among many scholars that plague was an idiosyncratic threat within the realm of colonial medicine. Mark Harrison has claimed that most people perceived plague as 'yesterday's disease' before 1894, a reminder of the unenlightened and insanitary conditions of the past, while Dorothy Crawford argues that it was only when this outbreak actually hit Hong Kong and threatened global trade interests that any serious preventive measures were taken or systematic research attempted.¹⁴ Despite the fact that later changes to the colony's medical infrastructures, though extensive, were more evolutionary than revolutionary, the economic implications of the epidemic certainly meant that a local sanitary issue drew global attention. As Robert Peckham states, 'The plague, with its epicentre in China, confirmed a perceived shift of global orientation eastwards from Europe to Asia and, in particular, to China.'¹⁵ While the economic importance of the colony is rarely debated, some scholars question Hong Kong's strategic significance as a vital link in Britain's imperial defences.¹⁶ But in the context of the plague pandemic, the actual economic and strategic significance of the enclave is of less importance than its professed prominence, just as the actual threat posed by disease outbreaks is of less interest than the *perception* of danger. As plague spread, municipal leaders in Hong

Kong fell increasingly under pressure to act decisively. Global scrutiny and the potential introduction of international quarantine rules threatened the colony's economy, which depended on trade. This and the danger of mass emigration by the colony's transient labour pool were enough to prompt extensive alterations to municipal systems.

Cities like Hong Kong are of significance because, as imperial hubs of trade and transportation networks, they were amongst the first places to be affected by epidemic outbreaks of disease. As a result, they became cornerstones for imperial prevention measures against the spread of disease, and arguably developed to some extent with this purpose in mind. By the time plague arrived in the colony, Hong Kong was an intrinsic part of an imperial web spanning the globe and bound by new developments in transportation, technology and telecommunications. It was one of the busiest ports in the world, handling half of all Chinese imports and a third of exports, comprising 22 million tons of goods, 2 million more than London. Trade was facilitated by approximately 4,000 European residents working alongside 200,000 Chinese labourers, most of whom were Cantonese immigrants from the mainland.¹⁷ Although it was an overwhelmingly Chinese city, John Carroll has argued that Hong Kong was, to some extent, a multi-ethnic society comprising Chinese, Europeans, Americans, Armenians, Indians, Portuguese from Macau, Jews from Bombay and Eurasians, who gravitated towards segregated communities yet maintained extensive daily contact.¹⁸ Successive Governors noted that Hong Kong was a 'peculiar colony, unlike any other', founded not as a settlement but as a mercantile station and although a small overseas community slowly took up residence, it was not meant as a place for permanent British inhabitation but, rather, an important part of 'a commercial and not territorial empire'.¹⁹ Nevertheless, the city remained a gateway between East and West, a point at which the transference of people and ideas helped foster a space characterised by cultural tensions and interchanges.²⁰ However, the disassociated and transient nature of community, and the policies of retrenchment and *laissez-faire* governance adopted by both Britain and the various governorships, meant spending on societal infrastructures was limited and sanitary problems persisted for decades until expansive change was both catalysed and financially justified by instances of perceived socioeconomic crisis, for example the arrival of disease outbreaks.

The fragmented nature of the community was reflected in the medical services available, with hospital care often left to various charitable organisations. By 1894, the colony was equipped with around half a dozen hospitals including the Government Civil Hospital, which catered predominantly to the small European community and those of different ethnicities with governmental connections, and the Tung Wah Hospital, which embraced the principles of traditional Chinese medicine. However, the scale of the plague outbreak, when it hit the colony, warranted the rapid establishment of several supporting institutions, including the redeployment of the hospital ship *Hygeia* (1891), the Kennedy Town Infectious Diseases Hospital and the Glassworks Hospital.²¹ As might be expected, the quality of care varied between institutions, with the Tung Wah Hospital frequently criticised as an institution which ‘at present hardly deserves the name of Hospital.’²² The newly arrived European nurses were based predominantly at the Government Civil Hospital, although they did visit, sanitise and occasionally work shifts at other hospitals. Their indispensability was quickly established and firmly asserted by Dr James Lowson, then Acting Superintendent of the Government Civil Hospital, who felt the institution would cease functioning if they were moved, even on a temporary basis.²³

As the point of international origin, Hong Kong’s size, status and geographical location meant that plague, and any solutions developed to prevent future outbreaks, including the attempted implementation of a stratified and professional nursing system, would draw international interest. From the first days of the infection, the professed fiscal significance and insanitary conditions of Hong Kong’s Chinese districts internationalised the issue; the latter further strengthened by proximity to the apparent sanitary threat posed by mainland China and the Chinese workers who frequently migrated across the border. The established trope of the inherently unhygienic indigenous populace, and the danger their numbers and immediacy posed to European settlers, permeates governmental correspondence of the age as this example from the annual report of Dr Philip Bernard Chenery Ayres, appointed as the last Colonial Surgeon of Hong Kong in 1873, illustrates:

The habits of the Chinese do not assist in the sanitation of the house. In each of the partitions referred to is a bed on which the family sleep, under the bed is a poo poo tub, which is of glazed earthenware with a cover to it,

this is used for the night soil for the women and children, and is emptied according to the class inhabiting the house from once every two days to once a week. The bedding used by the Chinese is never washed, and among the lower classes they seldom wash themselves As for the roads and streets, Chinamen are to be seen pursuing their avocations on the paths and even in the roadway, throwing slops, animal and vegetable refuse out of their houses into the road at all hours The drain traps are openly used by coolies as urinals, and the stench so caused in some places is abominable ... the road always in a state of wet and filth from the refuse, offal and slops thrown out of the houses. If this is so in the principle thoroughfare of Hongkong [*sic*], what it must be in Tai-ping-shan, where few Europeans go, it is not difficult to imagine.²⁴

As plague cases began to appear in other treaty ports around the world, equally pathologised phobias surrounding local populations were again evoked. In this instance perceived crisis was so traumatic because it revealed not only the inherent weaknesses in the fractured and disparate medical systems that rapidly became overwhelmed as the number of cases rose, but also wider civic tensions surrounding such issues as the deplorable sanitary condition of several areas of the city, or the arguments presented by many foreigners that the indigenous population were intrinsically insanitary. As Mark Harrison has shown of the 'plague-like' disease that struck India in the 1830s, the illness, 'and what it is framing tells us about the imperial ideologies and the economic and political priorities of the colonial government'.²⁵ In Hong Kong, as in other locations, the outbreak consequently expedited the fulfilment of a longstanding political agenda of the colonial government that advocated, among other measures, the demolition and rebuilding of the "native Chinese" neighbourhood of Taipingshan, as well as providing an opportunity for the administrative justification of the substantial governmental expenditure required to implement such changes.

Crisis and policy

Among the governmental expenses that could now be justified, in the face of threat to the colony's economic future posed by the appearance of plague in their midst, was the recruitment of qualified British nurses. In Hong Kong, as in other treaty ports, the need for professional European nurses to replace the *ad hoc* system of indigenous

workers of both genders, and members of religious orders, predated their arrival by decades. Such shortfalls in the provision of care are likely to have arisen at least partly as a result of the colonial government's desire to keep administrative costs to a minimum and a bipartisan attitude of retrenchment towards the colonies in Britain, at least before the outbreak of the Second Boer War.²⁶

The same was not true of 'settler societies' like Melbourne or Sydney, cities that developed with the aid of the transplantation of entire administrative systems from Britain, including those related to the education of nurses.²⁷ In other colonial locations it required the presence of a medical crisis for local authorities to recognise the importance of good nursing, exemplified by the new approach to nursing and nursing infrastructures which had been developing in Europe and the USA since the mid nineteenth century. A mere twelve years before the third plague pandemic struck, Dr John Ivor Murray, Surgeon-Major and then Acting Superintendent of the Government Civil Hospital in Hong Kong, stated this need in his annual report:

As in former years, much of the credit of the good results attained in this institution is due to the care and assiduity of Dr. Cochran, the Resident Surgeon Superintendent; but the one great difficulty he has to contend with, and which apart from the mere defects of the building, he will continue to find the most embarrassing, is that of obtaining good nursing. The Chinese coolies are altogether unsuited to this employment and are utterly untrustworthy – and the few Europeans who are willing to serve in the capacity of wardmasters, are generally men who can obtain nothing better, and are only a degree superior, in many respects, to the Chinese. If it were possible to induce the Sisters of Charity to undertake this duty, the benefit would be incalculable.²⁸

In Hong Kong, as in other locations, the demand for trained European nurses must be viewed within the context of more general sanitary reforms designed to address the immediate threat of plague and at the same time, demonstrate that the colony was doing all it could to improve standards of cleanliness, in accordance with new understandings of hygiene science. The period between 1880 and 1914 saw significant shifts in the understanding of disease and the provision of healthcare, underpinned by transnational developments in biomedicine, economic priorities and broader social changes. The plague bacillus, for example, was first isolated in 1894 in Hong

Kong after an intercontinental race between Kitasato Shibasaburo, a Japanese bacteriologist and protégé of Robert Koch, and Franco-Swiss alumnus of the Pasteur Institute Alexandre Yersin.²⁹

Technology presented a double-edged sword: not only did it reshape disease prevention and healthcare policy, it also facilitated the mass migration of people, creating new pathways for the spread of disease. At the same time, new conduits for the exchange of knowledge on combating the spread of disease were being formed, not least by the movement of nurses from colony to colony. In Hong Kong, changes in sanitary practices (and the associated costs) were justified not only by new understandings of disease causation and the economic dangers posed by outbreaks in a city dependent on transnational commerce, but also, after the 1830s, as a result of changing scientific theories surrounding 'acclimatisation'. According to contemporary arguments, the various 'racial types' struggled to adapt to new climates; and new ideas surrounding ethnic constitutions and regional climates began to gradually affect administrative policy and were increasingly utilised to justify the disparity in death rates between European and indigenous populations. As a result, it was now the task of the colonial authorities to remake spaces in order to bolster health and meet their requirements.³⁰

By the time plague appeared in Hong Kong, medical and administrative authorities of most other colonial outposts were advocating the reshaping of the existing environment to improve the health of all concerned. In Hong Kong, however, foreigners continued to be advised to either adapt to their new environment or remain isolated from volatile indigenous elements. The arrival of British nurses was part of an ongoing wider redefinition and reformation of both medical and civic roles and spaces designed to improve the entire sanitary condition of the colony. These included the rebuilding of the native district of Taipingshan, the completion of the Tai Tam reservoir, the construction of the first designated mortuaries and the restructured role of hospitals throughout the city. Thus nurses were finally recognised as a fundamental part of the public health provision that Hong Kong had long required and now apparently could not function without. They would be a crucial part of the expansive hygienic reforms initiated by the third plague pandemic, many of which resulted in the increased demarcation and stratification of

Hong Kong's medical spaces and personnel. As nurses were increasingly viewed as an essential part of the clinic or hospital, as a locus of emerging biomedicine, they also became an advertisement for the provision of Western medicine within what Mary Louise Pratt has termed a colonial 'contact zone'.³¹

Such changes are discernible in etymological shifts visible in administrative correspondence from the colony; before the 1894 plague pandemic, the term 'nurse' was indiscriminately applied and could denote a private or missionary nurse of unspecified training and nationality, or any of the local men and women, referred to on other occasions as 'coolies', performing a range of custodial or nurturing functions inside the city's hospitals. After 1894 and the arrival of certified European nurses, the distinction between 'nurses' and 'sisters' became gradually more concrete, and many of those previously deemed 'nurses' became 'amahs' or merely 'prohibitioners', as restrictions determined by education, experience and ethnicity were implemented. The term 'Sister' now applied only to trained European practitioners or to the members of the French and Italian convents required to intermittently perform nursing functions during preceding decades.

Despite now being viewed as an essential part of healthcare provision, the employment of nurses, and the implementation of wider sanitary reforms, still required fiscal justification. The decades between 1880 and 1914 were a time of retrenchment for the British Empire, as the Gladstonian Liberal Party adopted, partially in response to the Second Boer War, the motto of 'Peace, Retrenchment and Reform', calling for reduced public spending and the removal of monopolies, arguing that they were undemocratic and that the Empire itself was a financial burden that impeded the development of Britain. Such policies had an effect on the changing provision of healthcare and the development of the nursing profession in the various colonial outposts of the British Empire. These changes were manifested in Hong Kong as concerns in response to demands for any increase in funding required to combat the arrival of plague. By the spring of 1895, Dr John Mitford Atkinson was not the only member of the colonial medical establishment to recognise the inherent value of the nine British sisters who had arrived to help combat the outbreak of plague, and his comments were echoed by other affiliates from the special

sanitary committee assembled to deconstruct and assess precisely how the infection had been managed within the colony. According to Dr Philip Bernard Chenery Ayres, encouraging more European nurses to come to Hong Kong 'would be very much for the benefit of the Colony'.³² His report continued that despite the acknowledged expense incurred by the colonial and home governments in this course of action, identifying and training local European or Eurasian replacements would be impossible, thanks to the unwillingness of resident women to undertake such rigorous instruction and the inability of the medical authorities to provide a nursing education equal to that available elsewhere.³³ The possibility of training Chinese nurses in the same capacity was tentatively raised but then rapidly dismissed. Miss Eastmond, now matron of the Government Civil Hospital and leader of the newly arrived sisters, was equally condemnatory when questioned about the professional potential of both European and Chinese residents of Hong Kong. Instead, after being encouraged to speak in terms of medical benefits rather than economic costs, she chose to advocate the recruitment of additional colleagues from the London hospitals if required, as it was the only way to ensure quality.³⁴

Dr Lawson agreed with Ayres in part. However, although when he considered the cost of bringing more professional nurses to the colony, and the need to provide those already there with sufficient leave to meet contractual stipulations and preserve their health, he balked at the prospect. He proposed instead a scheme for instructing Eurasian locals, who could then be utilised in the hospitals of Hong Kong before finding useful employment as private nurses throughout the treaty ports of China. Nevertheless, he was careful to state that these women would only ever be 'nurses', always subordinate to the invaluable European 'sisters'.³⁵ His plans were shelved as concerns regarding the maintenance of quality medical care, particularly that available to Europeans, and the questionable ability of local women to assume a vocation as personally and professionally challenging as nursing, superseded fiscal worries. Dr Atkinson was careful to note that:

His (Dr. James Lawson's) idea was that Eurasian girls should be trained at the Hospital. I do not think we could make any reduction in the staff of Sisters. I do not think it would be advisable to put these Eurasian girls on the same footing as the trained European nurses. They are not only trained European nurses but ladies, and these Eurasians would lower the status

of the nursing staff. They would require to be simply prohibitions, under European trained nurses; I would never appoint them on a level with the European nurses.³⁶

It is worth noting that such racially influenced views were not so prevalent in greater China, where the dominance of missionary hospitals meant that the frequently reiterated goal had always been to teach the Chinese to care for their own people. However, in locations administered to a greater or lesser extent by European powers, concerns surrounding the preservation of professional standards and racial boundaries, alongside an apparent commitment to improving local sanitary conditions, often took precedence over cost. Crisis provided an opportunity to ignore financial restrictions and justify longstanding objectives. It was perhaps internalised concerns surrounding cost, as well as a desire to capitalise on the associated professional kudos of introducing professional nurses to the colony, that caused Dr Lowson to identify nursing reforms as one of the triumphs of the plague:

If ever this Colony has had reason to congratulate itself it was when we were able to procure well-trained British nurses. I think the greatest compliment that I can pay these ladies is to say that had it not been for their presence there could have been no well-run epidemic hospital during last summer. Amateur nurses at the beginning of an epidemic, or indeed at any stage where there is a rush, are worse than useless, and multiply the worries of a medical officer *ad infinitum*; not only this but all outsiders took care to give our hospitals a wide berth. When the hospitals were crowded it was often a matter of difficulty for the Medical Officers employed to keep their meals in their stomachs. It would have been much harder if they had had to remain in constant attendance all the time as our Sisters had to.³⁷

Conclusion

While this chapter examines Hong Kong as a neglected case study in the history of nursing it also argues that the expansion of the city's medical infrastructures, like those of any colonial outpost, should be viewed in relation to developments in the metropole, as well as other locations throughout the Empire and beyond. This is not to argue that there was uniformity in nursing practice and education, or that it was universally replicable. Instead, the aim is to acknowledge the influence of other locations, while at the same

time to explore the factors that made nursing practice in Hong Kong inherently different, for example the ways in which British nurses were employed in the city, as well as the reluctance to use European or Eurasian women in similar roles. To adopt such a methodology allows us to challenge previously held misconceptions regarding the metropole–periphery binary, for example the argument that nursing education and practice was formulated and consolidated in the capital before being exported, inviolate and uncontested, to the colonies. When not bound by the limitations enforced by discussing nurses exclusively within the confines of chronological and geographical enclaves, we can at the same time acknowledge the fact that they, like other forms of colonial labour, were part of complex and nuanced circulatory network.

While the need for nurses, or the reform of existing nursing practice, may be longstanding in different locations, pragmatic and expansive change was often prompted by instances of perceived crisis in the form of wars and disease outbreaks. These events helped shape nursing infrastructures by creating unprecedented professional opportunities and mutually influential encounters, while at the same time acting as a sampling technique that highlights instances of institutional continuity and change. In the case of Hong Kong, the arrival of plague in 1894 exposed existing shortfalls in the fragmented medical institutions, an *ad hoc* approach to nurses that had previously served the colony. The incident was also used to financially justify the recruitment of the professional British nurses the local medical authorities had long felt the city required. In this case, crisis and the movement of medical personnel it prompted indicate that the arrival of British nurses was part of both local and international sanitary reforms, as Hong Kong dealt with the plague as part of an attempt to bring domestic healthcare standards up to those available elsewhere in the empire.

Notes

- 1 Private papers of E. J. Gould, MS 4364/34/6, Australian War Memorial, Canberra, ACT. Perdita M. McCarthy, 'Gould, Ellen Julia (Nellie) (1860–1941)', *Australian Dictionary of Biography* (Canberra: Australian National University, 1983), <http://adb.anu.edu.au/biography/gould-ellen-julia-nellie-6437/text11013> (accessed 18 February 2015).

- 2 Existing literature on the origins and development of the Anzac Legend is vast, but for an interesting further discussion on its specific feminisation see M. Lake and H. Reynolds, *What's Wrong with Anzac? The Militarization of Australian History* (Sydney: New South Books, 2010) and P. Rees, *The Other Anzacs: Nurses at War 1914–1918* (Crow's Nest, NSW: Allen & Unwin, 2008).
- 3 Notable exceptions to this trend include A. Digby and H. Sweet, 'Nurses as culture brokers in 20th century South Africa', in E. Waltraud (ed.), *Plural Medicine: Tradition and Modernity, 1800–2000* (London: Routledge, 2001), pp. 113–29; J. Howell, A. M. Rafferty, R. Wall and A. Snaith, 'Nursing in the tropics: nurses as agents of imperial hygiene', *Journal of Public Health*, 35 (2013), 338–41; M. Jones, 'Heroines of lonely outposts or tools of empire? British nurses in Britain's model colony, Ceylon 1878–1948', *Nursing Inquiry*, 11:3 (2004), 148–60; D. Solano and A. M. Rafferty, 'The rise and demise of the Colonial Nursing Service: British nurses in the colonies, 1896–1966', *Nursing History Review*, 15 (2007), 147–54.
- 4 T. Ballantyne, *Webs of Empire: Locating New Zealand's Colonial Past* (Wellington: Bridget Williams Books, 2012).
- 5 W. Anderson, 'Second opinion: making global health histories: the post-colonial worldliness of biomedicine', *Social History of Medicine*, 27 (2014), 372–84.
- 6 See S. Hodges, 'The global menace', *Social History of Medicine*, 25 (2012), 719–28.
- 7 The passenger manifest of the *Canton* has her returning for her second stint in Hong Kong on 4 March 1898. Ancestry.com, 'UK, Outward Passenger Lists, 1890–1960'.
- 8 *Nursing Record and Hospital World*, 2 July 1898, p. 6, and *British Journal of Nursing*, 7 February 1903, p. 103.
- 9 C. Anderson, *Subaltern Lives: Biographies of Colonialism in the Indian Ocean World, 1790–1920* (Cambridge: Cambridge University Press, 2012); A. Lester and D. Lambert (eds), *Colonial Lives across the British Empire: Imperial Careering in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2010).
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 - 16 F. Welsh, *A History of Hong Kong* (London: HarperCollins, 1993), p. 285.
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