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Training the 'natives' as nurses in Australia: so what went wrong?

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Introduction

The story of the Aboriginal women who participated in Australia's nursing history remains largely untold. In the first six decades of the twentieth century, Aboriginal people were confronted with harsh exclusionary practices that forced them to live in settlements, reserves and missions.[1] While many Aboriginal women worked in domestic roles (in white people's homes and on rural properties), small numbers were trained at public hospitals and some Aboriginal women received training to be 'native nurses' who worked in hospitals on settlements

In this chapter, an indigenous historical lens is applied to the status of Indigenous nurses and midwives in Australia. I explore the establishment of Australia's nursing profession, and compare training of white nurses with training received by 'native nurses'. I suggest that Australia failed to respond to the British Colonial Nursing Service's agenda and argue that this failure, in part, contributed to the poor health status experienced by Indigenous Australians. I propose that four issues underpin the history of Indigenous nursing in Australia: the rise of social Darwinism, Australia's Dominionship status, Acts of Parliament in Australia relevant to the lives of Indigenous people, and a lack of critical mass of Indigenous people. I provide three case studies from Queensland (Woorabinda, Cherbourg and Palm Island) of the early history of training Indigenous nurses in Australia.

Aboriginal and Torres Strait Islander people face the poorest health outcomes of any population group in Australia. At birth, the current life expectancy for Indigenous Australian men is 67.2 years, 11.5 years

less than the life expectancy of non-Indigenous men (78.7 years). For Indigenous women, the life expectancy at birth is 72.9 years, 9.7 years less than that of non-Indigenous women (82.6 years).[2] Many complex factors underpin this life-expectancy gap. One important but commonly overlooked factor is the number of Indigenous Australians working within the health system. Evidence suggests that improvements in Indigenous health are strongly linked to increased numbers of Indigenous people working in health service delivery.[3]

Throughout Australia's history, there have been ongoing calls for increased numbers of Indigenous nurses and midwives.[4] For example, as early as 1934 a Queensland parliamentarian, Mr Kenny, 'criticised certain aspects of the aboriginal administration, and … advocated the training of aboriginal nurses for aboriginal races'.[5] Kenny was one of a small number of voices in Parliament who advocated for better Aboriginal health outcomes. Interestingly, he supported a protectionist agenda by promoting 'aboriginal nurses for aboriginal people'. In 1979, the Australian Aboriginal Health Report noted that:

> There are no Aboriginal doctors, few nurses and nurse trainees, and a limited number of nurse aides. One important way of improving Aboriginal health is to have Aboriginals themselves filling these positions. It is therefore necessary that as many Aboriginals as possible be trained in these professions in the shortest time possible.[6]

In 2011, Indigenous staff made up just 0.8 per cent of the nursing and midwifery workforce, even though Indigenous people accounted for 2.5 per cent of the total population. The 2011 Nursing and Midwifery Labour Force Survey identified that 2,212 of Australia's nurses and midwives identified as Aboriginal and/or Torres Strait Islander, with 1,414 working as registered nurses and 798 working as enrolled nurses. New South Wales had the highest number of Indigenous nurses, and less than one quarter (24.6 per cent) were employed in Queensland.[7]

Establishing nursing as a profession in Australia

This history of nursing in Australia was influenced by changes in nurse education in Britain, largely led by Florence Nightingale. Strachan suggests that, prior to the 1860s, nursing in Australia was regarded as a lowly occupation and was mostly undertaken by untrained men and

women who worked in institutions. Between 1860 and 1890, training emerged as a necessary prerequisite for the role, and nursing became almost exclusively an occupation for women of education.[8]

In 1863, the widow of the New South Wales Chief Justice wrote to Nightingale, asking her to send trained nurses to Australia. The plea initially fell on deaf ears but, in 1864, doctors in Sydney requested that the Board of the Sydney Infirmary employ a small number of trained sisters from the Council of the Nightingale Fund. They argued that the 'doctors at the Sydney Infirmary were sure that nurses were the key to any effective cure'.[9] In 1868, six nurses who had been trained and appointed by Florence Nightingale arrived in Sydney to 'take charge of nursing' in the colony. They worked under the leadership of Lucy Osburn. In 1871, one of the original six nurses, Sister Annie Miller, was appointed as matron of Brisbane Hospital. By 1886, the Brisbane Children's Hospital was awarding certificates to white nurses of European extraction who had completed formal training there and achieved a standard of competency.[10]

In the late 1890s, nursing was increasingly professionalised in Australia. Hospitals became training centres for nurses. In 1899, the Australasian Trained Nurses Association (ATNA) was formed. It committed to four main aims:

1. promoting the interests of trained nurses in all matters affecting their work as a class;
2. establishing a system of registration for trained nurses;
3. affording opportunities for discussing subjects bearing on the work of nurses;
4. initiating and controlling schemes that would afford nurses a means of providing an allowance during incapacity for work caused by sickness, accident, age or other necessitous circumstances.[11]

ATNA was a voluntary association that was founded in Sydney by concerned nurses and medical practitioners. As a voluntary body, it had no legal powers to enforce the standards it promoted. During the first half of the twentieth century, ATNA worked to professionalise nursing and delineate the standards relevant for a trained nurse.[12] The early history of nursing in Australia shows little acknowledgement that Indigenous Australians might be involved in the delivery of healthcare and be trained as health workers. Indigenous nurses and midwives are notable only by their absence. Prior to invasion, Aboriginal and Torres

Strait Islander people practised their own approach to medicine and healthcare. Health knowledge was passed down from generation to generation through a strong and successful oral tradition. Medicines and health resources were based on what was locally available. For Aboriginal people, hospitals with a professional staff of nurses and doctors made no sense. In addition, the Western approach of treating illness did not fit with the understanding of holistic healthcare.

Before her nurses were sent to Australia, Florence Nightingale conducted research about the health of Aboriginal Australians. Her interest in Indigenous health was established during a meeting with Sir George Grey, 'who had discussed with her the apparent deterioration and gradual disappearance of native races after contact with white civilisation'.[13] Nightingale applied to the Colonial Office for funds to carry out research 'to ascertain, if possible the precise influence which school training exercised on the health of native children'.[14] She was successful in receiving funding, and devised a 'simple school form' to send to the native schools of the colonies. She received responses from Western Australia and South Australia, and presented her research in York (UK) in 1864.[15]

The responses that Nightingale received from Australia were highly racist and showed gross ignorance. Aboriginal people were described as 'savages', 'uncivilised' and in urgent need of being brought into civilisation. In the mid-1800s, when Nightingale conducted her research, 'civilising' Aboriginal people involved conversion to Christian beliefs. Aboriginal spirituality was not acknowledged, and people's spiritual beliefs were not regarded as an essential part of their health and identity.

Within Nightingale's writings, there is no acknowledgement of the efficacy of Aboriginal traditional medicines. Only one person who responded to Nightingale hinted at the value of traditional medicines: Bishop Salvadore noted:

> A native belonging to the institution became ill with spitting of blood; a sure mark of fatal disease, if the patient is treated in the usual way. The patient begged to be allowed to go into the bush; and after days hunting of horses, he returned sufficiently recovered to resume his occupations.[16]

This is obviously a direct quotation from Bishop Salavadore: 'hunting horses' in colonial periods was largely undertaken by indigenous

men. The meat and the leather of horses was heavily utilised and also provided some sort of income for Indigenous men, as horses could be sold for both their meat and hides (for leather). It also meant for the men that they could continue traditional hunting activities to hone the skills required to hunt. It also meant accessing traditional food sources and not the introduced food sources which were prevalent on the reserves and missions and had little nutritional value in comparison with traditional diets – it is possible that the combination of traditional medicine, exercise and diet was responsible for his recovery.

During the period of early nurse education and the establishment of hospitals as training sites, the wives of white settlers wrote about the value of Aboriginal birthing practices. For example, an elderly 'Dame Mary Gilmore in the 1930's recollected that Aboriginal women were preferred to European Doctors or nurses in isolated areas [throughout Queensland] in the days before cleanliness was considered a virtue in medicine'.[17] Historian Helen Gregory recognises the value of Indigenous understandings of healthcare when she notes:

> Professional nursing and midwifery in Queensland is just over 120 years old. However the application of particular skill and learning to care for the sick, women in childbirth, the injured, the frail aged and the very young in Queensland is far older than that. Nursing history in Queensland encompasses traditional Aboriginal practices, as well as the gradual evolution of nursing education and practice on a western model.[18]

Historical factors influencing the health of Indigenous Australians

The poor health status faced by Indigenous Australians can be understood through an historical lens. Since the invasion and colonisation of Australia, Indigenous Australians have experienced many Acts of Administration that have defined their lives, limited their movements and controlled their occupations. The different approaches to Indigenous administration fall into four broad groups: the period of British invasion and settlement (from 1770 to around 1824), the period of occupation and extermination of Indigenous people (from 1824 to around 1908), the period of protection and segregation (which

started around 1873 in Queensland before spreading throughout the rest of Australia and continuing until around 1957) and the period of assimilation (which extended from around 1957 until 1980).[19]

Wearne describes the first phase of Australia's history thus:

> The history of early contact between the invaders and Aboriginal peoples across Australia was one of violence and unofficial war which lasted well over 70 years. During these early days of invasion the English government involvement was minimal and sporadic with loose administrative structure and oversight of Aboriginal peoples.[20]

While the popular narrative defines the early history of Australia as frontier years, the reality for Aboriginal Australians was very different. Massacres were rife throughout the country with little, if any, retribution against the offenders. Warne estimates that, at a conservative estimate, 10,000 Aboriginal people died violently in Queensland during this time.[21] Land owners who were expanding the British Empire through agriculture and cattle development believed that the land was theirs for the taking. They paid little or no regard to Aboriginal clans and nations who had lived on the land for more than 40,000 years.[22] There are many documented accounts of settlers who poisoned water holes and offered infected blankets to Aboriginal people. At the same time, introduced diseases such as smallpox and sexually transmitted infections had a devastating impact on Aboriginal populations.[23]

During the era of occupation and extermination, Aboriginal people were seen as vermin to be removed. In 1859, Queensland separated from New South Wales. Soon after separation, the administration of Aborigines was transferred to the Colonial Secretary of Queensland.[24] In 1880, *The Queenslander* newspaper published the following: 'I trust that you will succeed in bringing about the much-to-be desired reform you advocate, and ameliorate both white and black, the former into unquestioned possession of the vast area of the colony, the latter off the face of the earth which they do not even serve to ornament.'[25]

The era of protection and segregation emerged when Australia's governments realised that Aboriginal people were not dying out as expected. Legislation to control Aboriginal people was first enacted in Queensland, with the Aboriginal Protection and Restriction of the Sale of Opium Act 1897 (61 Vic, no 17). Frankland described the Act thus: '[It] was the first comprehensive Aboriginal protection act in

Queensland and, indeed, Australia: it ushered in the long era of protection and segregation during which Aborigines and Torres Strait Islanders lost their legal status as British citizens and became, in effect, wards of the State.'[26]

The Act authorised mass removal of Aboriginal peoples from their traditional homes to settlements managed by either Church or government. A Chief Protector was nominated for Queensland, because Aboriginal people were seen as wards of the state. This ensured that mass relocations occurred without retribution. Throughout Queensland, non-Aboriginal people were appointed as district protectors or mission superintendents, and were given powers under the Act to decide: where and how Aboriginal people were to live and work; when or if they could practise cultural ceremonies or could marry; whether and when they could move on and off the settlements; whether wages should be removed and whether Aboriginal people should be imprisoned without offence.[27] Only minimal education was offered to their children and Aboriginal girls who reached around twelve years of age were sent across Queensland to work as domestic servants on white-owned cattle stations. They had no choice about this work, and often were not paid. By 1914, there was an emerging awareness of the value of Aboriginal workers and concern about decreasing numbers of Aboriginal children. The Governor of Queensland, McGregor, reported that: 'The most remarkable fact in connection with all the camps I have seen is the paucity of children. … This is very regrettable for several reasons, but more especially because it will become more difficult to work the north-west stations when there are no more natives to assist.'[28] McGregor's comments here clearly shows that 'natives' were heavily utilised to undertake the hard physical work on cattle stations. Indigenous men were mostly used as they were much cheaper for the pastoralists and cattle station owners to employ. In many instance not having to pay Indigenous men equal wages as non-indigenous men doing this type of work was crucial for the successes of this industry. If there was a paucity of children there was then a paucity of young Indigenous men to be able to undertake this role.

This was therefore a period of extreme segregation throughout Australia. Very few Aboriginal women succeeded in entering hospitals to pursue careers in nursing. Applying for exemption to leave

a reserve and begin nursing training was an arduous task. In some cases, Aboriginal women were able to enter nursing or midwifery by denying their Aboriginality. These women, who had one white parent (usually a father), had to apply for exemption from the Act. They signed paperwork confirming that they would cease identifying as Aboriginal and would not socialise with Aboriginal people. The era of protection and segregation saw a devastating decline in the health of Aboriginal people.

Blood quantum[29] was frequently used within the settlements as a strategy for segregating people and controlling their access to both education and healthcare. Many people believed that Aboriginality could be 'bred out'. To reflect this, settlements were often set up with segregated groups including the Superintendent's house, a house for the white staff (usually a teacher, matron and nurses), the half-caste dormitory for children who had one white parent and the full-bloods' camp. Differences between the living conditions and health status of these groups became increasingly obvious. By the 1940s, some government officials were beginning to record the disparities evident on settlements and questioning the ways they were administered.

In 1943, Dr Johnson, a visiting medical officer to Woorabinda Settlement in Queensland, was damning in his report to the Department of Home Affairs. He argued that the health of Aboriginal people was being devastated by exposure to new infections (such as gastro-enteritis), a change of diet causing impaired nutrition (with Aboriginal people shifting from a nutritious diet to a poor diet of damper, bully beef, tobacco and tea), contamination of the milk supply (the contamination came from a dried mix that was not being boiled before consumption), contamination of the water supply (the creek water was probably liable to bacterial infection, caused by new settlers and grazing cattle) and sexually transmitted infections (which were introduced into Australia by the settler population).[30] Johnson's report also stated:

> The housing was inadequate, and the buildings cold and draughty. Many Aboriginals slept on the ground in winter, and the blanket issue was insufficient. In January alone there were 31 deaths the majority of which were due to gastro-enteritis and pneumonia, both of which are preventable by adequate diet and living conditions.[31]

5.1 Half-caste dormitory

In reporting on the staff at Woorabinda, he further noted that the appalling conditions and high death rates of Woorabinda were in part due to the staff, who were 'made up of three officers of the Department who are too fond of drinking, a mentally unstable Matron and a professionally negligent Medical Officer'.[32] Johnson's report was part of the regular monthly reports sent to Brisbane from each settlement in Queensland. The superintendent, visiting medical officer and matron provided monthly reports which were compiled in Brisbane into one report for the Chief Protector. Little attention was paid to Johnson's comments at the time, and life on the settlements continued unchanged.

The Colonial Nursing Association: training nurses for the colonies

The Colonial Nursing Association operated in Britain for seventy years (1896–1966), recruiting British nurses for work in the colonies (it was renamed the Overseas Nursing Association in 1919). It recruited more than 8,000 nurses for overseas placement.[33] Rafferty

5.2 Full-bloods' camp

and Solano suggest that British nursing in the colonies reached its 'zenith' at the height of colonial rule, and subsequently declined as the colonies achieved independence and trained nurses locally. They describe three interlocking strands of the Colonial Nursing Service's work: 'expanding the colonial service through the work of nurses in government hospitals, providing nursing services for private institutions, and contributing to the development of the so called "native" nursing services'.[34]

In Australia during the first half of the twentieth century, little attention was given to the possibility (or value) of training Indigenous nurses and midwives. In Britain, however, a committee was established in 1943 'to examine the question of the training of nurses for the Colonies'.[35] The committee worked under the chairmanship of Lord Rushcliffe, and was established by the Colonial Secretary. After a preliminary survey of the position of nursing services in colonial territories, two sub-committees were formed to consider retrospectively both the training of nurses in the United Kingdom and the Dominions for services in the colonial territories and the training given in the colonies to Indigenous nurses.

In August 1945, the Colonial Office presented to Parliament its *Report of the Committee on the Training of Nurses for the Colonies* (the

Rushcliffe Report). The report identified that training of nurses in the United Kingdom and the Dominions for services in colonial territories was comprehensive. It gave a thorough overview of training needs and requirements of nurses, midwives and mental health nurses. While it recommended training of Indigenous nurses, it paid little attention to local complexities that might influence the likelihood of training, noting:

> At first the only trained nurses were those who were recruited in the United Kingdom and the Dominions or from nursing sisterhoods in Europe, but it was speedily recognised that no great extension of medical services could take place unless the greater part of the nursing staff was drawn from the local populations.[36]

In Australia, the recommendation to train Indigenous nurses fell on deaf ears. As a Dominion, Australia was not required to adopt recommendations from 'the mother country'. In addition, Australian policies such as the Acts of Administration, which made training Indigenous nurses difficult, were not considered within the context of the Rushcliffe Report.

Aboriginal people working as 'native nurses'

Throughout much of the twentieth century, government policies in Australia largely excluded Indigenous people from careers such as nursing. On the settlements, however, Aboriginal people worked in many different healthcare roles, often with little formal recognition, pay or training. In an era of rapidly declining Aboriginal health, Aboriginal women worked in the health system to 'combat' devastating illnesses facing their peoples.

Many government-run settlements faced acute staffing problems. White nurses were difficult to recruit, and staff turnover was rapid. The matron's notes at Woorabinda Settlement, for example, repeatedly report that the white nursing staff had been reduced to the matron only. Aboriginal women from the full-bloods' camp and traditional medicine men were frequently called on to treat community members and administer medicines. Their knowledge of Aboriginal languages and cultures made them indispensable to the white nursing staff.

By 1942, the monthly reports sent to the Deputy Director in Brisbane outlined the difficulties in attracting and retaining white nursing staff on the missions of Woorabinda, Palm Island and Cherbourg in Queensland. However, the report stated that: 'Hospital efficiency was maintained despite the difficulties experienced in keeping the nursing staffs up to the required strength. In all cases coloured nurses are used to the fullest and the services rendered by them is commendable and invaluable.'[37] Basic training programmes for 'native nurses' had begun to emerge in Queensland's settlements during the 1940s. Records about 'native nurse' training schemes exist for Woorabinda, Cherbourg and Palm Island, which were gazetted as Aboriginal Settlements between 1901 and 1927 and operated as such until the 1970s.

Matron Joan Olive Colledge began working at Woorabinda Settlement Hospital in 1942. She was the daughter of Woorabinda's first superintendent, H. C. Colledge. In his 1943 report, Johnson described H. C. Colledge as an 'uncouth individual, fond of complaining and rather addicted to alcohol'.[38] His daughter, Matron Colledge, was educated at Woorabinda in the white children's school. She received her General Nurse Certificate in December 1940 and her Midwifery Certificate in 1943. Soon after taking her position at Woorabinda Mission, Matron Colledge began a formal correspondence with the Director of Native Affairs, Mr O'Leary. In her letters, Matron Colledge outlined her plans for a formalised training scheme, designed to train the 'native' girls as nurses. She suggested that the scheme would replace the current *ad hoc* training received by the Aboriginal women who were crucial to the running of the hospital.

Matron Colledge's scheme was designed for Aboriginal girls who showed an interest in nursing. She planned to recruit them for an initial three-month probation period and, if probation was successfully completed, sign them on for two years of training. She suggested that:

> During training the native nurses would receive lectures by the Medical Officer and Matron on all nursing subjects, including general nursing, obstetrics, child welfare, nutrition, hygiene, anatomy etc. The native nurses would … be required to undertake periodical written and practical examinations and … at the termination of two years of training and provided they could successfully pass the set examination, the trainee would be issued with a certificate or badge of efficiency. …They will be trained to take care of

> the sick, sponging helpless cases, making beds, sweeping wards, taking temperatures in the earlier months of training and later to do dressings, bandaging, urine testing and other necessary treatments. They will be lectured in Hospital Etiquette etc …. After two years of Hospital work, lectures etc, these girls will be a great asset to the Hospital staff and could be transferred to other Settlements if necessary. They will be given the usual Nursing duty hours and with their day off weekly and should be at the end of 2 years be classed as an experienced nurse.[39]

While Matron Colledge stated that trainees would, after two years, be classed as 'experienced nurses', it is important to note that they were not expected to be nurses for the broader Australian community. Her plan was to train 'native nurses', who could work under the supervision of white nurses and could provide healthcare for Indigenous patients. The nurses who were trained under Matron Colledge's programme would be able to work at Woorabinda or on other settlements, not in other hospitals, and in August 1945, she received approval for her plans, agreeing that, 'such trainees are to be paid the wage of 12/6 per week. The Matron is to furnish monthly reports on their progress to the Office.'[40] She initially employed two young Aboriginal women. On 12 September 1945, she wrote to the Director of Native Affairs: 'I wish to advise that Doreen Bosun and Gwen Doyle the chosen assistants are at present doing well and are a great asset to the hospital. They are at present doing alternative shifts in the Wards and out patients Department.'[41] Matron Colledge appears to have been an advocate for improvements in Aboriginal health. There is scant evidence of her approach to social justice issues. However, we can assume she operated from a protectionist stance in view of her decisions about native nurses only providing care to Aboriginal patients and her agreement that the 'native nurses' only work on other missions. The 'native nurses' received a badge of efficiency and not a qualification.

Perhaps inspired by Matron Colledge's plans at Woorabinda, the Under-Secretary to the Director of Native Affairs in Queensland wrote to Matron Rynne at Cherbourg Settlement Hospital, suggesting that a similar programme should be developed at Cherbourg.[42] In a letter from August 1945, from the Department of Native Affairs to the Cherbourg Superintendent, the Under-Secretary asked: 'What steps, if any, are being taken to train native girls as nurses to assist in staffing native hospitals?'[43] Cherbourg's Matron Rynne advised

the Superintendent 'that there was no prescribed Training Course in operation at the Cherbourg Hospital'.[44] However, she noted that: '12 native girls are employed as assistants in nursing and no difficulty has been experienced in maintaining this number. The question of training Native Nurses is a particularly difficult one and many problems must be solved before a satisfactory scheme is evolved.'[45]

There is no detailed account of 'native nurse' training in Cherbourg. Matron Rynne's reply suggests her lack of interest in starting a 'native nurses' training scheme and clearly shows how each matron's opinion was critical in the schemes' establishment. International calls for training Aboriginal women not as 'native nurses' but as qualified nurses (as in the Rushcliffe Report) were meaningless without the support of the local matron.

The matron of Palm Island also received a letter from the Director of Native Affairs asking about her plans to train Indigenous nurses. Matron Thompson wrote back supporting the plan, with the assistance of Palm Island's Medical Officer, Dr Short. Her letter supported the 'training of half-caste and aboriginal girls as native nurses in the Palm Island Hospital'.[46] Matron Thompson had spent twelve years working in the Solomon Islands before moving to Palm Island. In her letter, she stated: 'I was Matron of Hospitals for 12 years, I trained Island girls to a standard of efficiency, enabling them to perform all nursing work under white qualified supervision. The girls on Palm Island have qualifications and adaptability equal to the island girls.'[47]

She then developed a training programme that differed from the one being used by Matron Colledge at Woorabinda, no doubt as a result of her experience of training in the Solomon Islands. She developed a three-year training programme, following an initial three-month probation period. This was the first proposal to provide Aboriginal nurses with the same period of training as white nurses in the public hospitals.

In a May 1947 submission outlining the programme, Matron Thompson proposed that trainee nurses would receive regular lectures from both nursing and medical staff. She outlined her desire for 'Palm Island Hospital to be officially recognised as a Training Hospital for native nurses, the intention being that the Scheme can apply to other than Palm Island natives'. She proposed that 'at the end of termination of three years' training and provided she can successfully

pass the set examinations, the trainee be issued with a Certificate or Badge of Efficiency'. The Palm Island Medical Officer, Dr Short, added to this in his statement of support: 'I believe that if education facilities here were more advanced it would be possible to train girls here to a standard required by the Queensland Nursing Services (i.e., become registered nurses).'[48] This appears to be the first suggestion in Queensland that Aboriginal women could potentially become fully qualified nurses.

Matron Thompson's correspondence shows her requests for resources to support her training programme. She requested equipment such as notebooks, nursing texts, a blackboard and a physiology chart before the programme could begin. In early 1948, Palm Island's Superintendent Sturgess wrote to the Director of Native Affairs noting that the programme was now in operation, with four 'native' girls having commenced and further nursing assistants also attending the lectures.[49]

The nursing care provided by the trainee nurses of Palm Island was well regarded. The Medical Officer, Dr Smith, wrote:

> In April to June of 1947 upon my arrival to take up duties four months ago, an epidemic of measles was in full swing. Of the 169 cases dealt with, we had no complications during or following the outbreak. This can be attributed to the nursing staff at the hospital. We were then as we are now, under staffed with white nurses and the brunt of the work fell upon native nurses. I cannot speak too highly of them and the services that they rendered. They are worthy of special mention in this respect. Their devotion to the duty at this period certainly justified the introduction of the Native Nurses Training School which was recently inaugurated.[50]

Records of the 'native nurses' training scheme

From 1947 until well into the 1950s, the 'native nurses' training schemes were consistently mentioned in the Reports of the Director of Native Affairs. The settlements of Woorabinda, Cherbourg and Palm Island recorded various levels of success. The 1948 Report of the Director of Native Affairs stated: 'Another strong thing is the high results obtained in the examination papers set out periodically to test their knowledge of nursing subjects. The teaching follows closely the curriculum of the great teaching hospitals.'[51]

However, one of the key problems faced by the training programmes, perhaps not surprisingly, was a lack of white staff to provide ongoing training lectures. The 1950 Report of the Director of Native Affairs stated that 'the difficulties being experienced in respect of tuition of the trainees will be noted from the medical officers' report. However, the training already received by the trainee nurses has in no small measure assisted in maintaining very efficient hospital services.'[52]

The training and employment of native nurses continued on government settlements well into the 1950s. In the late 1950s, regular reporting about these training schemes ceased, primarily because the structure of settlements began to change. In the late 1950s, hospitals on settlements began to be transferred across to become the responsibility of the nearest or largest public hospital. Local 'native nurse' training schemes ended.

As Australia entered the 1960s, the period of protection and segregation came to an end, and Australia entered an era of assimilation. Popular policy deemed that segregation of Aboriginal Australians was no longer appropriate, and that Aboriginal people should be assimilated into white Australia. In theory, this meant that Aboriginal people could apply to train as nurses or midwives in any public hospital in the country. Of course, entry into training was at the discretion of the hospital matron. Aboriginal women experienced difficulties in applying for and being accepted into nursing training.[53]

The 'native nursing' training programmes offered on settlements such as Woorabinda, Cherbourg and Palm Island offered an opportunity for Aboriginal women to be trained as nurses. But their training was different from the training available to white Australian women, and their employment options were markedly different. Native nurses worked under the direction of white nurses, and they worked predominantly with Aboriginal people and within Aboriginal communities.

The story of 'native nurses' is in stark contrast to the story of white Australian nurses. During the period of protection and segregation, the Australasian Trained Nurses Association and the Australian Nursing Federation worked hard to nourish collegiate bonds among nurses. Ongoing training was available; for example, the Queensland Branch of the Australian Nurses Federation began postgraduate

lecturers on a range of topics such as industrial nursing, municipal nursing (including immunisation), school nursing and bush nursing.[54] At this time, Aboriginal health was not thought of as a specialised area of nursing that required any particular knowledge or training.

Australia is different from many other British colonies in its approach to the training of Indigenous women as nurses and midwives. Other colonies, such as India and South Africa, actively drew local Indigenous women into nursing and midwifery throughout the colonial era. In Australia, there was an overwhelming assumption that Indigenous women were not recruitable or trainable as nurses and midwives. Overarching racist beliefs were reflected in the government policies of forced relocation, protection and segregation.

It seems likely that Australia's failure to respond to the Colonial Nursing Service's agenda (1896–1966) and the Rushcliffe Report (1945) was based in four broad issues: social Darwinism, and the enthusiasm with which it was adopted in Australia; Australia's Dominionship status, which gave it independence from British legislation; Acts of Parliament in Australia, which allowed for forced relocation of Aboriginal people; and the lack of a critical mass of Aboriginal people, who were quickly outnumbered by the white settlers.

Social Darwinism was wholeheartedly embraced in Australia during the era of protection and segregation. This racial theory applied Darwin's biological theory of evolution to the evolution of societies. It provided support for the notion that some races and cultures were superior, while others were inferior (almost non-people). The prevailing belief in racial 'survival of the fittest' was widespread, and many people believed that Aboriginal people were 'the missing link' and would soon die out. As Andrew Markus noted, 'one doesn't have to read extensively to discern that a central concern of anatomists was to establish whether Aboriginals were closer to the animal than human'.[55] Between the 1920s and 1940s, Aboriginal people living on the settlements were a treasure trove for the curiosity of scientists and academics who sought to advance the cause of social Darwinism.[56] As a result, thousands of Aboriginal Australians were subjected to the study of the scientific and anthropological communities. Of course, forced relocation of Aboriginal people on settlements and giving them no rights to prevent the experiments made the process easier.

The Dominionship status gained by Australia led to a lack of accountability for the government's treatment of Aboriginal people. Australia's fully autonomous status was confirmed in 1926 at the Imperial Conference in London. While autonomous, Australia retained its allegiance to the Crown. Dominionship 'removed any remaining restrictions on legislative autonomy in those realms, except regarding legislation about succession to the throne'.[57]

With autonomy, Australia was not answerable to the British government for its treatment of Indigenous Australians. Australia implemented its agenda of protection and segregation – in a way not dissimilar to more recent attempts at apartheid. Australia's Dominionship status led to the Acts of Parliament that established settlements as the places where Indigenous Australians would be forcibly relocated. These Acts had direct and devastating impacts on Aboriginal health which continue to be seen today. In addition, by forcing Aboriginal people to live together as groups segregated from the broader society, frequently with many different nations and clan groups living together in ways that had never happened before, Aboriginal people experienced highly restricted education and employment options. Living on settlements made it largely impossible for Aboriginal women to train as nurses in public hospitals.

In Australia, Aboriginal people are a small proportion of the overall population. This lack of a critical mass of Indigenous peoples, combined with the fact that Australia's Indigenous peoples consist of multiple separate nation groups, was unique to Australia. Most of the other Dominions had large, stable Indigenous populations. The number of Aboriginal Australians living in Australia at the time of invasion will always remain unknown. However, it quickly became apparent that Aboriginal Australians were relatively small in number. With the rapid increase in colonial migrants, the concerted efforts of genocide through massacre and warfare and the impact of introduced diseases, the numbers of Aboriginal peoples living in Australia declined dramatically.

Conclusion

Examining the early history of nursing in Australia provides important insights into the health crisis currently facing Australia's Indigenous

people. Australia largely ignored the Colonial Nursing Service's agenda, with its call to train Indigenous people as nurses. Instead, Australia's developing nursing profession relied on overseas-trained nurses and locally trained nurses from the settler population. Aboriginal people were excluded from the nursing profession.

During the era of segregation and protection, Indigenous Australians were forced to live on settlements run by either the state or the Church. Healthcare services were limited, and the health of Indigenous Australians rapidly declined under the poor living conditions. Staffing difficulties in the settlement hospitals led to training programmes for 'native nurses'. In the Queensland settlements of Woorabinda, Cherbourg and Palm Island, for example, there is good evidence that 'native nurses' were trained to support white nursing staff. However, these 'native nurses' were permitted to work in settlement hospitals only, not in the broader community.

The 'native nurse' training programmes came to an end in the late 1950s, when Australia entered an era of assimilation and, in theory, Indigenous women could then train as nurses. Since the 1960s, there has been a gradual increase in numbers of Indigenous women being trained as nurses and midwives. However, the legacy of their exclusion from health work remains evident, with proportionally few Indigenous people working as nurses and midwives and with ongoing health challenges confronting Australia's Indigenous population.

Notes

1 Settlements, missions and reserves were established throughout Australia, starting in Queensland with the 1897 Aboriginal Protection and Restriction of the Sale of Opium Act. They were run either by the state or by churches. Throughout this chapter, I use the term 'settlement' to refer to the various settlements, missions and reserves.

2 AIHW (Australian Institute of Health and Welfare), *Life Expectancy and Mortality of Aboriginal and Torres Strait Islander People*. Cat. no. IHW 51 (Canberra: AIHW, 2011).

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