

**WORKING PROFESSIONALISM: NURSING IN WESTERN CANADA,
1958-1977**

by

Margaret Rose Scaia

Bachelor of Science in Nursing, University of British Columbia, 1999
Masters of Nursing, University of Calgary, 2003

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in Interdisciplinary Studies

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University of Victoria

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Supervisory Committee

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Supervisory Committee

Dr. Mary Ellen Purkis, (Faculty of Human and Social Development)
Co-Supervisor

Dr. Lynne Marks, (Department of History)
Co-Supervisor

Dr. Annalee Lepp, (Department of Women's Studies)
Outside Member

Abstract

Changes in women's relationship to caring labour, and changes in societal attitudes towards women as nurses during the period when they became union members and aspiring professionals, are revealed in thirty-seven oral history interviews with women who became nurses between 1958, a pivotal time in the development of the publicly funded health care system, and 1977, when the last residential school of nursing closed in Calgary. This study challenges the historiography that suggests that nursing programs of nursing in the 1960s and early 1970s were sites of unusual social regulation, and that nursing was a career choice that women made because of a lack of other more challenging or rewarding alternatives. This study also challenges assumptions that women in nursing were unaffected by the feminist movements of the 1960s and 1970s and instead passively accepted a position of gendered subservience at home and in the workplace. Instead, I argue that nurses skilfully balanced work and other social responsibilities, primarily domestic caregiving, and also were active in unionization and professionalization in advance of other Canadian women workers. The ability of nurses to maintain a prominent position in health care, to advocate for the conditions needed to provide the best nursing care possible, while also fighting for improved working conditions and higher professional status is an impressive story of how women in these decades used gender, and class, as tools to enact social change. These efforts are all the more impressive when considered within the context of social opposition faced by nurses as they both resisted and conformed to expectations that their primary role was as wives and mothers. Nurses negotiated this challenging political terrain by framing their work in terms of its practical necessity and gendered suitability as women's paid employment. In

making these claims, I position nursing and nursing education as a form of women's labour that exemplifies employed women's struggles to promote fairer wages, better working conditions, and access to the full benefits of economic and social citizenship for all women. This challenge to the prevailing assessment of nursing during this period establishes the main thesis of this dissertation.

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Acknowledgments

In this journey, perhaps not of love, but certainly of dogged determination to KBO (Churchill), I want to thank the women who told their stories and shared their world of nursing and the events of their early adulthood and careers in nursing with me. Coming to academia and nursing later in my life, I always felt on the outside of both these worlds. Through the women who shared stories of their early life in nursing, and the many colleagues at the School of Nursing at UVic who have been so supportive of my work, I finally felt a sense of belonging and community in both the worlds in which I spend so much time and energy. In particular, thank you for the unflagging support of my committee members, Dr. Mary Ellen Purkis, Dr. Lynne Marks, and Dr. Annalee Lepp who have taken me down a road of intellectual challenge that would never have been possible without the uniqueness of each of their accumulated wisdom, scholarship, and persistence. Many thanks, many times, to you three brilliant and patient scholars!

A special debt of gratitude goes to my dear friends at Selkirk College, particularly Donna Van Vliet, and to Lynne Young and my dear sisters Mary and Katy ... what can I say but thank you for being my sisters and being there for me! Also—my dearest husband Jack, you're the best-- always there for me!

Dedication

This dissertation is dedicated to my very best mother, Lorraine Scaia, the memory of my grandmother, Ethel Scaia, and the one and only Mildred Bell. Also, how can I ever thank you, my best and dearest friend Kate Bird, for your tireless enthusiasm, support, and love—I promise, this is the last time!

CHAPTER ONE

Women Who Became Nurses

Women who became nurses in the 1960s and 1970s are the majority of nurses, educators, and nurse leaders in Canada and the United States today. Many will retire in the next ten years and be among the first cohort of professionally educated women who will experience the social and economic benefits of their own employment-based pensions, and be among the first generation of women to combine a professional career with marriage and motherhood. According to nursing and labour historian Mark Roth, the early education and career experiences of these women reflect a time when, “for women, the professional career presented a contradiction. While public service and morality were acceptable pursuits, their primary role was still in the domestic sphere ... nursing was to be a middle class profession, but an inherently gendered one defined by obedience to male doctors, female virtue, caring, sacrifice and lower pay. The effects of this arrangement on nurses would be felt for decades to come.”¹

Although gender dynamics have changed since the period covered by this study, the 1960s and early 1970s, and assumptions about women’s subservience to men have been challenged, nursing remains a gendered profession. In fact, according to Statistics Canada, only 5.1 percent of the 230,957 nurses in Canada in 2002 were male.² Nursing continues to be defined primarily as a women’s caring profession, and thus it is easy to make the assumption that because the majority of nurses are women, there is

¹ Mark Roth, “*The Gendered Workings of Class in Postindustrial, Service Sector Capitalism: The Emergence and Evolution of the British Columbia Nurses Union, 1976–1992*” (master’s thesis, Simon Fraser University, 2008):16.

² Canadian Institute for Health Information, “Workforce Trends of Registered Nurses in Canada, 2002,” with data from the Registered Nurses Database (Ottawa: CIHI, 2003). Available for free download at the CIHI website, www.cihi.ca.

homogeneity in why women choose nursing and how they understand nursing work. Historical approaches that essentialize nursing and essentialize women contribute to these assumptions. In contrast, stories from thirty-seven women who entered and worked in nursing in Calgary and Vancouver that are documented in this dissertation, reveal that gender was not the only axis of identity that defined the experience of women in nursing in the 1960s and 1970s. Race, class, sexuality, and religion were also influential in shaping individual and collective experiences and in facilitating how women conformed to and resisted dominant norms. These women's stories challenge the established view, expressed by Susan Reverby, that "the ideology of nursing, based on nineteenth-century understandings of women's duties, but not of women's rights, gave trained nursing purpose but limited its power to control or define its occupational or professional existence."³ Their experiences suggest a more nuanced and complex story of how nurses resisted limitations imposed by gender and claimed professional status, while simultaneously defending their roles as women, workers, wives, and mothers.

The term "Professional Nurse" has not been easy to define, nor has it been easy to assign. Changing discourses around the ideology of "professionalism" in nursing are prominent in most historiographies. According to Beatrice Turkoski, definitions of nursing professionalism envisioned by the Canadian Nurses Association in the 1950s and 1960s were based on assumptions about male-dominated hierarchies of power.⁴ Similarly, Judith Wuest claims that unsettling conflicts within nursing about the use of the term "professional" has meant that the discourse of professionalism "has been a

³ Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987): 2.

⁴ Barbara B. Turkoski, "Professionalism as Ideology: A Socio-Historical Analysis of the Discourse of Professionalism in Nursing," *Nursing Inquiry* 2, no. 2 (1995): 84.

vehicle of both liberation and oppression ... Professionalism has played a key role in marginalizing nursing and in constraining knowledge development.”⁵ Because nursing has been defined as the professionalization of caring, and has, simultaneously, been denied the status accorded male professions because of its association with women, how the term is defined, restrictions on who can claim to be a professional nurse, and the value of that claim, have, since the 1960s and early 1970s, become a symbol of broader social issues for women, including women’s demands for gender accommodation, equality, and recognition in the home, education, and workplace.⁶

To claim professional status, young women needed an education. After formal schools of nursing were established in the early twentieth century, young women generally became nurses through a three-year unpaid residential apprenticeship in a hospital-based program, followed by a brief period of low-paying graduate nursing work, which was, in turn, followed by marriage and motherhood and resignation from nursing. Little occurred in the immediate post-war decade to challenge this regime because for most working- and middle-class nurses, like women in the broader society, the ideology of the male breadwinner implied that women did not expect, nor were they expected, to make a living wage.⁷ As Nancy Christie claims, the ideology of maternalism, with the man as family breadwinner, underwrote the legitimacy of this assumption. Christie contends that maternalism persisted as a social norm well into the 1960s. Social programs such as the mother’s allowance were predicated on the maternalist ideal of women as

⁵ Judith Wuest, “Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective,” *Journal of Professional Nursing* 10, no. 6 (1994): 357.

⁶ Wuest, “Professionalism:”357-367.

⁷ Beth Light and Ruth Roach Pierson, *No Easy Road: Women in Canada 1920s to 1960s* (Toronto: New Hogtown Press, 1990); Joan Sangster, *Transforming Labour: Women and Work in Post-War Canada* (Toronto: University of Toronto Press, 2010).

primarily mothers and wives. The ideology of maternalism was “a result of a broader consensus regarding the norms of the male political economy, which was based on the ideal of masculine family independence ... with its insistence on public endowment [of motherhood] in exchange for women’s reproductive service to the State.”⁸ In other words, social programs rewarded the gendered norm of men as wage earners, and women as unpaid caregivers.

The shift that occurred in the 1960s and 1970s in married women’s employment patterns, began, according to the Veronica Strong-Boag, during the Second World War when Canadian women entered the paid labour market due to financial necessity, work opportunities created by the war effort, patriotism, the encouragement of the Canadian government, and, individual ambition.⁹ Increasingly, in the fifteen-year period following the war, women remained in the paid labour market, even following marriage, with more women returning after their first child began school. As Strong-Boag has argued, predictions that Canadian women would rather stay home in peace time proved wrong. In the ten years between 1951 and 1961, employment of married women had doubled. Strong-Boag attributes this shift to “much more permissive attitudes to female labour and the desire to take advantage of unprecedented opportunities for mass consumption further mobilized women after the war.”¹⁰

Some social historians of the women’s movement have attributed the acceptability of women’s greater participation in the paid labour market to the resurgence of feminism in the post-war period. Gail Campbell identified two waves of feminism, the first-wave

⁸ Nancy Christie, *Engendering the State: Family, Work, and Welfare in Canada* (Toronto: University of Toronto Press, 2000): 97/98.

⁹ Veronica Strong-Boag, “Canada’s Wage-Earning Wives and the Construction of the Middle Class, 1945-60,” *Journal of Canadian Studies* 29, no.3 (1994): f-6.

¹⁰ Strong-Boag, “Canada’s Wage-Earning Wives”: f-9.

peaking in the late nineteenth and early twentieth century, and the second-wave reaching its zenith in the 1960s and early 1970s.¹¹ While these dates have been debated, Campbell argues that in Canada, it was the grass-roots, liberal second-wave feminist movement that is credited with instigating the Royal Commission on the Status of Women (RCSW) in 1968 that investigated the unequal positioning of women in Canada in regard to the quality of their lives at home and in the workplace. Liberal second-wave feminists were not the feminists who grabbed media attention through public protest. As such, their message was probably more palatable to working- and middle-class women and society in general. The activities of liberal feminists, who focused on gender equality, as opposed to labour feminists, who focused on women's right to waged labour in respect of their primary responsibilities as wives and mothers, was that, "did not involve public protests or public meetings, though when we look, we find such women protesting, both individually and collectively, and consistently involved in the quest for equality and justice for themselves and for other women."¹² The feminist movement in the 1960s in Canada thus provided a means for women to challenge the assumption that they did not have to, nor want to, work outside the home. Annis May Timpson explains that, as the second-wave feminist movement gained traction in Canada, "women began to develop a sustained critique of the employment inequalities they experienced and pressure their governments to address the problem through policy innovation and change."¹³

The demand for social change at the level of social policy and practice was

¹¹ Gail G. Campbell, "'Are we going to do the most important things?' Senator Muriel McQueen Fergusson, Feminist Identities, and the Royal Commission on the Status of Women," *Acadiensis* XXXVIII, no. 2 (Summer/Autumn 2009): 53.

¹² Campbell, "'Are we going to do the most important things?'" 54.

¹³ Annis May Timpson, *Driven Apart: Women's Employment Equality and Child Care in Canadian Public Policy* (Vancouver: UBC Press, 2001): 3.

alarming for many who benefited from women's unpaid labour in the home, and for many women who chose to remain in the home. According to Veronica Strong-Boag, the alarm around women's rejection of traditional caregiving roles was a result of post-war uncertainty about gender roles, particularly within the middle class. Strong-Boag comments that, "Ostensibly middle-class wives and mothers freely choosing to enter the paid labour force deeply troubled Canadians trying to reconcile contradictory notions of the roles women ought to assume in order to ensure the good life for all."¹⁴ The good life, however, and even maintaining existing social standards, increasingly called for a second income. According to Strong-Boag, initially, in the 1960s, this emerging reality, especially for working-class Canadians, had a limited impact on the popular view that working women took jobs that should have gone to male heads of households.

Married nurses were leaders in challenging this assumed order, and in confronting prevalent notions of working motherhood. The demand for nurses under the expanding welfare state transformed nursing from an occupation suitable for single women to an opportunity for married women to forge a new identity as professional working wives and mothers. Analysis of interviews with women who experienced these changing times serves as a case study of broader social trends in the 1960s and 1970s in which women increasingly rejected their inferior social and economic status, the primacy of marriage and motherhood, and the unsuitability of paid employment for working- and middle-class married women. Because nurses, as women, shaped and were shaped by these governing discourses, a reconceptualization of nurses' responses to broader social trends supports new understandings of how women and nurses utilized existing and new sources of

¹⁴ Strong-Boag, "Canada's Wage-Earning Wives:" f-2.

power to advance, influence, and enact more favourable conditions that enabled them to enjoy a greater share in the benefits of economic citizenship, while also allowing them to fulfill their roles as wives and mothers.

As a Researcher

How am I positioned in this research? As a woman, a nurse, a professional, and a worker, I am, like many women, somewhere in between, conforming to and resisting dominant gendered discourses. I was a member of the last cohort of students that graduated from a three-year nursing diploma program from Selkirk College in Castlegar B.C. in 1997. Coming from a working-class background, I had been making outdoor equipment on a home sewing machine for twenty years and would continue to do so for another ten. The idea for a change in career came as a result of the realization in my late 30s that being a middle-aged female labourer had limited potential for long-term economic stability. I had spent four years in colleges and universities after high school, but the lure of the back-to-the-land movement drew me away from the city, and it was a long time before I fully re-entered the realities of the “capitalist” world. Thus, at forty, I cast about for a means of earning an income that had social value, was consistent with my social-justice “60s” values, did not discriminate on the basis of gender or age, and would assure me of immediate and lasting employment. I chose to become a nurse.

After completing my diploma, I continued my education and obtained a baccalaureate and then a master’s degree in nursing, and finally entered the doctoral program at the University of Victoria four years ago in Interdisciplinary Studies. I chose an interdisciplinary approach because I wanted to look at nursing history from a critical feminist perspective, and the discipline of history offered such a perspective. I was and

am strongly influenced by the second-wave feminist movement, and earlier in my career as a nurse I would cringe when someone asked me what I did for a living. I continued to say I was a seamstress even after I obtained my master's degree in nursing. And yet, as I came to know nursing and its history as a female profession, steeped in significant contributions to the long-standing aims of feminism and social justice, I developed a new appreciation of how nurses had been able to maintain high ethical standards and a commitment to worthy social causes in the face of conflicting and competing discourses about the meaning of nursing and what it means to be a professional nurse.

In “advancing” my education, I also came to understand the ways that society rewards those who conform. Over the years, I have shifted my social and income status not so much because I became a better nurse, but because I took the opportunity to enter academia at an advanced level. This action attuned me more acutely to the ruling discourses within nursing, which have increasingly privileged academia in the last three decades, and to which I became a contributor.

While nursing became a passion over time, it was my interest in women's history that drove my interest in nursing history. Through formal courses in women's and gender history, I came to see how the tools of critical feminist analysis had been employed by historians in the 1970s and onward to excavate “women's” history from the broader field of social history by looking at the everyday experiences of women within wider social, political, and economic contexts, considering how factors such as gender, race, class, and culture had shaped their lives.¹⁵ Likewise, being a nurse in academia made me aware that

¹⁵ Jeanne Boydston, “Gender as a Question of Historical Analysis,” *Gender & History* 20, no. 3 (2008): 558–583; Eileen Boris and Joan Sangster, *The New Women's Labor History* (Durham, NC: Duke University Press, 2006); Nancy Christie, *Engendering the State: Family, Work, and Welfare in Canada* (Toronto: University of Toronto Press, 2000); Franca Iacovetta and Mariana Valverde, *Gender Conflicts: New Essays in Women's*

the history of nursing had more recently undergone a similar reassessment. Using the same lens of feminist analysis, the everyday experiences of front-line nurses were examined, broadening the reigning historiography of more well-known leaders, educators, and administrators.¹⁶ By choosing an interdisciplinary approach, I hope to contribute to the discipline of nursing, and to bring attention to the contribution of nursing to women's labour history. This contribution is informed by the complexity of my own life, and how different it was in comparison to the lives of many of the women with whom I work.

When I met most of my colleagues at the University of Victoria, they were at a stage in their lives, after a long career in nursing, when their professional status was grounded in accomplishments not just in academia but, perhaps more profoundly, in what appeared to be the shared identity of being a particular kind of nurse. For many of these women, that particular kind of nurse had been shaped in the hospital-based programs across Canada in from the 1950s to 1970s. This shared social memory was built on the changes and challenges they faced as young women in these decades and included not only their experiences as hospital-based nurses, but also their early experiences of marrying and bearing children, and the politics of balancing these sometimes conflicting positions. At the same time, as an educator in nursing, I came to understand from the

History (Toronto: University of Toronto Press, 1992); Linda Kealey and Franca Iacovetta, "Women's History, Gender History and Debating Dichotomies," *Left History* 4, no.1 (1996): 221-37.

¹⁶ E. D. Baer, "'Do Trained Nurses...Work for Love, Or Do They Work for Money?'" Nursing and Altruism in the Twenty-First Century," *Nursing History Review* 17 (2009): 28-46; Alice J. Baumgart, "The Conflicting Demands of Professionalism and Unionism," *International Nursing Review* 30, no. 5 (1983):150-55; I. J. Bramadat and K. I. Chalmers, "Nursing Education in Canada: Historical 'Progress'—Contemporary Issues," *Journal of Advanced Nursing* 14 (1989): 719-726; Cynthia Toman and Marie-Claude Thifault, "Historical Thinking and the Shaping of Nursing Identity," *Nursing History Review* 20 (2012), 184-204; Patricia D'Antonio, "History and the Humanities," *Nursing History Review* 18 (2010): 10-11; Christina Bates, Dianne E. Dodd, and Nicole Rousseau, *On All Frontiers; Jayne Elliott, Meryn Stuart, and Cynthia Toman, Place and Practice in Canadian Nursing History* (Vancouver: UBC Press, 2008).

literature that the hospital-based programs represented a “dark” period in nursing history, “the horse and buggy years” according to a brochure compiled for high-school counsellors promoting the new college-based programs of the 1960s.¹⁷

The idea of the “horse and buggy” years of nursing emerged as a result of a broader critique in the feminist literature about the association of women with low-paying, low-status work based on assumptions that women were “naturally” caring. Feminists drew parallels between caring as the focus of nursing work and a metaphorical “horse and buggy” era of women’s history, when it was assumed that women were “naturally” caring, but caring was seen as inferior to masculine qualities such as acting, doing, and thinking. Through this feminist lens, professions like nursing were scrutinized and found wanting; in fact nursing was seen as antagonistic to the egalitarian aims of second-wave feminism.¹⁸ The experiences of women who graduated during this “dark” period contradict this evaluation. Rather, in this dissertation, I argue that women in nursing have made a unique contribution to women’s labour history that has yet to be fully recognized.

Participants

To come to a more critical understanding of this contribution to women’s labour history, I examined the experiences of thirty-seven women who entered nursing in their late teens (16 to 19 years old) between 1958 and 1977. The women in this study graduated from seven different schools of nursing in Calgary, Alberta, and Vancouver,

¹⁷ *A Nursing Career: Material Compiled for High School Counsellors*, Calgary General Hospital School of Nursing Reports, 1963–1970, CGH School of Nursing fonds., M2456-293, Glenbow Museum, Calgary.

¹⁸ William Carroll and Rennie Warburton, “Feminism, Class Consciousness and Household-Work Linkages among Registered Nurses in Victoria,” *Labour / Le Travail* 24 (1989): 131–145; M.E. Holliday, and D. L. Parker, “Florence Nightingale, Feminism and Nursing,” *Journal of Advanced Nursing* 26, no. 3 (1997): 483–488; Susan Gelfand Malka, *Daring to Care: American Nursing and Second-Wave Feminism* (Urbana: University of Illinois Press, 2007); Eleanor J. Sullivan, “Nursing and Feminism: An Uneasy Alliance,” *Journal of Professional Nursing* 18, no. 4 (2002): 183–184.

British Columbia. All attended hospital-based programs, including those who graduated from the University of British Columbia (UBC) School of Nursing. All identified themselves as white, working- and middle-class women with an orientation to the Christian religions, a demographic profile that continues to dominate the profession. Participants came from both urban and rural communities in and around Vancouver and Calgary.

Emerging Themes

Four dominant themes emerge from the interviews and serve to organize the presentation and analysis of the interviews. Briefly, the first theme focuses on women's attraction to nursing, entering nursing school, and the experience of being a student nurse in the hospital-based programs. The second theme focuses on the period when students graduated from nursing school and began to balance paid employment, marriage, and motherhood at a time when domestic responsibilities dominated women's social roles. The third theme focuses on challenges that emerged as women sought to establish themselves as workers and professionals. The fourth theme, emerging from the last, considers the implications of divisions within nursing arising from competing definitions of professionalism. While front-line nurses employed traditional definitions of professionalism inherited from nursing's military and religious traditions, as well as a shared understanding of nursing work, those in supervisory, management, and teaching positions sought a new definition of professionalism based on academic credentialing.

Desiring Nursing

The first theme I explore is what attracted women to nursing. Closely aligned with the attraction to nursing was the image of nursing, the limited availability of other forms

of professional employment, and the availability of the hospital-based programs. In many media forms in the 1950s and 1960s, such as television, movies, children's books, romance novels, magazines, and stories about adventurous and virtuous women such as Cherry Ames, nursing was portrayed as an occupation for unmarried and, in some cases, married women that conferred authority and social acceptability.¹⁹ Nursing uniforms often reflected current fashion trends, nurses had a degree of economic independence that was unusual for women at this time, and they also had a different kind of relationship with men in authority—doctors in particular—that conveyed an unusual degree of collegiality between genders for this period.²⁰ The independence of the nursing residence was also attractive. In the hospital-based diploma programs,²¹ students lived in residences attached to the hospital for three years and could not be married or live out of the residence. For young unmarried women, living away from home was unusual, and these arrangements offered a degree of independence from parental supervision that some women found attractive. Finally, the low cost of a nursing education, and the guarantee of employment, was attractive to young women and their families when funds for a girl's education, and opportunities for respectable employment for women, were scarce.²²

Despite the respectability of nursing, the independence of the nursing residence, and the low cost and guarantee of employment that nursing offered, the historiography of this period identifies the hospital-based programs as a detriment to the advancement of

¹⁹ Kathryn M. McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990* (Toronto: Oxford University Press, 1996).

²⁰ Rondalyn Kirkwood, "Blending Vigorous Leadership and Womanly Virtues: Edith Kathleen Russell at the University of Toronto, 1920–52," *Canadian Bulletin of Medical History/Bulletin Canadien d'histoire de la médecine* 11 (1994): 175–205.

²¹ Although university programs existed in this period, they were not the dominant models of nursing education.

²² Gradually, over the period of this study, these low-cost hospital and residential programs closed and were replaced by three-year college and four-year university programs.

nursing and the shift from hospital-based to academically-based programs as progressive. As Elizabeth Herdman explains, “Faith in progress is manifested in nursing historiography and contemporary nursing literature, in the basic tenet of nursing orthodoxy, that professionalization is both inevitable and desirable, in the alignment of nursing with medical science and technology and the belief that Western nursing is the model for nursing world wide.”²³ Those who have written this narrative of progress in nursing are largely the women who had the power and influence to move this agenda forward and to benefit by it. In contrast, this study troubles the assumed benefits of a narrative of progress and complicates the assumptions upon which it is based, suggesting a new interpretation of these changes and the desirability of their outcomes for nursing.

Working Motherhood

The second theme I explore is the trend in Canada in the post-war period among working- and middle-class women to continue to work following marriage and motherhood. Nancy Christie and Veronica Strong-Boag have looked at this trend broadly, but nursing has not been a focal point of analysis or has been understudied in this context.²⁴ The possibility that nurses were among the avant-garde of this feminist and economically inspired movement has received little attention from nurses, feminists, or women’s labour historians. The tensions experienced by the women who participated in this study, and their strategies of balancing work, marriage, and motherhood at a time when society privileged the stay-at-home mother, suggest new interpretations and new ways of looking at how nurses were able to use existing images of nursing as women’s work and reconfigure them to meet rising expectations for paid employment and upward

²³ Elizabeth A. Herdman, “The Illusion of Progress in Nursing,” *Nursing Philosophy* 2, no. 1 (2001), 4.

²⁴ Christie, *Engendering the State*, 4–5. Strong-Boag, “Canada’s Wage-Earning Wives:” 5–25.

social mobility. While the feminist literature positions nursing as a subservient profession that reified the virtue of submission, the experiences of the women I interviewed suggest a different story.²⁵

Feminist Influences

The third theme I explore considers how women in nursing positioned themselves in relation to mainstream feminist movements, specifically labour feminism and liberal second-wave feminism. According to Dorothy Sue Cobble, it was the labour feminist movement that represented the interests of working-class women, while liberal feminism, a variation of feminism within the more popular second-wave movement, focused on gender equality in the home and workplace, including equal opportunities for education and income.²⁶ Labour feminists, according to Dorothy Sue Cobble and Annis May Timpson, advocated for the rights of women in the paid labour force who also bore the major responsibility for family care.²⁷ In contrast, Cobble argues that second-wave feminism, specifically liberal feminism, focused on promoting opportunities for individual women, often at the expense of social issues of concern to both men and women. Liberal feminism also ignored the potential compounding impact of race and culture as marginalizing forces in working-class women's lives.

Cobble claims that labour feminists and liberal second-wave feminists needed to realize their common goal—the recognition of women's real lived experiences—in ways that addressed fundamental inequalities based on gender, class, and culture. In a remark

²⁵ Florence Melchior, "Feminist Approaches to Nursing History," *Western Journal of Nursing Research* 26, no. 3 (2004): 340-355; Julie Fairman, "Not All Nurses Are Good, Not All Doctors Are Bad," *Bulletin of the History of Medicine* 78, no. 2 (2004): 451-60; Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982).

²⁶ Dorothy Sue Cobble, *The Other Women's Movement: Workplace Justice and Social Rights in Modern America* (Princeton: Princeton University Press, 2004).

²⁷ *Ibid.*; Timpson, *Driven Apart*.

that is relevant to nursing, Cobble suggests that “a movement was needed [labour feminism], then as now, that refused to romanticize market work and that sought a world in which mutualism and care were just as valued as individual achievement and power.”²⁸ Cobble’s analysis of differences within the feminist movement, specifically between liberal second-wave feminism and labour feminism, show the two streams were not antagonistic in their ultimate aims. According to Cobble, there were levels of complexity within feminism that direct us more to common threads than discordant tones. This dissertation examines the equality agenda of the liberal second-wave feminist in relation to nurses entering academic programs, while the emphasis on accommodation for women’s caregiving responsibilities brings attention to a labour feminist ideology.

Unionism and Professionalism

The fourth theme that emerges from the interviews, building on the last, concerns divisions within nursing arising from competing definitions of professionalism. Increasingly, working-class women were joining labour organizations and demanding attention to wages and workplace conditions, such as part-time work, flexible shifts, maternity benefits, retention of seniority, and pensions. Alternatively, women were demanding access to higher education, and the social and economic privileges that appeared to flow from an academic credential. In the past, the definition of professionalism in nursing was based on the knowledge, skills, service, and altruism of mainly single women. The military and religious traditions of nursing also emphasized the duty of the nurse to her profession above all other obligations and interests.

²⁸ Eileen Boris, “Roundtable on Dorothy Sue Cobble’s *The Other Women’s Movement: Workplace Justice and Social Rights in Modern America*,” *Labor: Studies in Working-Class History of the Americas* 2, no. 4 (2005): 62.

Professional nurses were expected to put the care of their patients first and their private lives second.²⁹ Those who shaped and maintained this professional identity did not generally consider how the domestic obligations of married women with children influenced the work or image of nursing.

Changes in women's relationship to work, family, and the economy, and the demand for nurses, began to alter this traditional definition. What emerged were two competing but not necessarily hierarchical discourses. One discourse related to the attempt to maintain elements of professionalism based on service and altruism, while also balancing the responsibilities of marriage and motherhood. Proponents of the competing discourse saw opportunities to strengthen existing alliances within academia and to nest traditions of service and altruism, which defined nursing as a woman's profession, within a broader definition established in male-dominated professions such as law and medicine. These nurses, capitalizing on advantages already accrued through class privilege, have most often positioned themselves, and been positioned, as having contributed more significantly to "the progress" of nursing over the past fifty years.

In the early post-war years, women's limited opportunities in higher education, and their restricted access to social, political, and economic power, meant that nursing was one of the few occupations in which women, whether working- or middle-class, could claim the title "professional."³⁰ Describing oneself as a professional nurse in these decades had less to do with academic credentials than it did with claiming the knowledge

²⁹ Diana Mansell and Dianne Dodd, "Professionalism and Canadian Nursing," in *On All Frontiers*, ed. Dianne E. Dodd, Nicole Rousseau, and Christina Bates, (Ottawa: University of Ottawa Press, 2005): 197-212; David Coburn, "Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective," *Labour / Le Travail* 34 (1994): 139-161.

³⁰ McPherson, *Beside Matters*; Nona Y. Glazer, "'Between a Rock and a Hard Place': Women's Professional Organizations in Nursing and Class, Racial, and Ethnic Inequalities," in special issue on Marxist feminist theory, *Gender and Society* 5, no. 3 (September 1991): 351-372.

and skills involved in caring for patients. Through the hospital-based programs, front-line nurses, nurse managers, and nurse educators reinforced the importance of caring and the skills that made caring possible. Increasingly, however, an academic degree in nursing, rather than a three-year nursing diploma, became the criteria that validated the knowledge and skills of nursing and allowed practitioners to claim professional status.³¹

Differences in claims to professionalization also reflected class differences within nursing. These differences were reflected in the broader society, where the working class performed manual labour—for example the tasks of bedside nursing—and those in the middle and upper classes performed managerial tasks.³² In the first half of the twentieth century, a perceived shared professional identity built on the religious and military heritage of nursing permeated the historiography of nursing. Shared educational experiences, and dominance of bedside nursing, served to reinforce this sense of common identity regardless of credentialing.³³ This understanding was increasingly challenged in the 1960s and 1970s as nurses with differing professional credentials and specializations, nurses from different cultural and racial backgrounds, and the demands of married nurses with child care responsibilities created a diversity of allegiances and alliances as nurses sought to meet their divergent and sometimes conflicting goals. Specialization within nursing served to fracture the hegemony of bedside nursing skills as the hallmark of

³¹ Ina J. Bramadat and Karen I. Chalmers, “Nursing Education in Canada: Historical ‘Progress’—Contemporary Issues,” *Journal of Advanced Nursing* 14, no. 9 (1989): 719–726.

³² Timothy Brennan, “Intellectual Labor,” *South Atlantic Quarterly* 108, no. 2 (2009): 395–415; Robert Dennis Hiscott, *Career Paths of Nursing Professionals: A Study of Employment Mobility* (Ottawa: Carleton University Press, 1998); Lynn Ilon, “Knowledge, Labour and Education,” *Compare: A Journal of Comparative and International Education* 30, no. 3 (2000): 275–282; J. L. Kinnear, “The Professionalization of Canadian Nursing, 1924–32: Views in the CN and the CMAJ,” *Canadian Bulletin of Medical History / Bulletin Canadien d’Histoire De La Médecine* 11, no. 1 (1994): 153–74.

³³ Mansell and Dodd, “Professionalism and Canadian Nursing,” Christina Bates et al., *On All Frontiers*; Veronica Strong-Boag, “Making a Difference: The History of Canada’s Nurses,” *Canadian Bulletin of Medical History / Bulletin Canadien d’Histoire De La Médecine* 8, no. 2 (1991): 231–48; Diana Mansell, *Forging the Future: A History of Nursing in Canada* (Ann Arbor, MI: Thomas Press, 2004).

professional expertise.³⁴ As Damien Brennan explains, “It would appear that this [tension]... has provided the social context in which nursing has rejected the status associated with vocation, duty and obedience and has developed an anxiety to achieve occupational status by pursuing strategies of professionalism and practice based on scientific truths.”³⁵

Contribution Of This Study

This study disrupts and challenges existing interpretations of nursing in the 1960s and early 1970s. Interviews with women who became nurses in these decades complicate the belief that all nurses were devoted to the care of their patients, service to society, and obedience to dominant gender norms. The stories of women educated in the hospital-based programs, particularly in the residential hospital-based programs, suggest a different interpretation of these “dark days” of nursing education and contradict the assumption that young women were merely exploited as a source of cheap labour and then willingly took up their proper place as wives and mothers.

The contribution I hope to make to nursing and women’s history is guided by the work of Brenda Cameron, Christine Ceci, and Anna Santos Salas, who ask us to examine the obvious, the taken-for-granted, and those assumptions that “go without saying.”³⁶ Questioning assumptions about nursing, such as the value of the hospital-based programs, or conflicting definitions of professionalism serves to challenge the certainty of the

³⁴ Baumgart, “The Conflicting Demands of Professionalism and Unionism,” 150-55; Alice J. Baumgart and Rondalyn Kirkwood. “Social Reform Versus Education Reform: University Nursing Education in Canada, 1919–1960,” *Journal of Advanced Nursing* 15, no. 5 (1990): 510–516; Alice J. Baumgart, “Hospital Reform and Nursing Labor Market Trends in Canada,” in “Hospital Restructuring in North America and Europe: Patient Outcomes and Workforce Implications,” a supplement to *Medical Care* 35, no. 10 (October 1997).

³⁵ Damien Brennan, “Commentary. The Social Construction of ‘Woman’s Work’: Nursing Labour and Status,” *Journal of Nursing Management* 13, no. 4 (2005): 283.

³⁶ Brenda Cameron, Christine Ceci and Anna Santos Salas, “Nursing and the Political,” *Nursing Philosophy* 12, no. 3 (2011): 153.

narrative of progress that is deeply embedded in the history of science, to which nursing has strong affiliations. For example, the stories of the women in this study suggest that nurses were politically astute in harnessing the power of unions, feminism, professional associations, and the media to achieve their multiple goals; they were not passive bystanders in the women's movements that swept the social landscape of Canada and the United States. Their conflicting goals and strategies created antagonistic divisions within nursing that reverberate today, and this points to the need for a more complex understanding of the social and historical roots of the directions and priorities that inform current nursing education and practice. A closer examination of the complexity of nurses' experiences in these decades suggests that nursing historians must continue the work, begun in the 1990s by scholars such as Kathryn McPherson, to complicate and question nursing history and recognize the multiple voices and multiple sources of power within nursing.³⁷

Sources

The sources I draw on in this study include thirty-seven interviews with women who became nurses in Vancouver and Calgary between 1958 and 1977. I chose these two cities and schools of nursing in order to focus on two close but distinct locations.

Vancouver and Calgary are two western Canadian cities, close to the Canada–United States border, both surrounded by rural farmland, and both reliant on a resource-based economy during the period under study. Both cities had similar hospital-based programs, although Vancouver had established a school of nursing in 1919 at the University of British Columbia. Until the late 1960s, the University of Alberta in Edmonton offered Alberta's only degree program in nursing, but the distance between Calgary and

³⁷ See McPherson, *Bedside Matters*.

Edmonton created barriers for Calgary students wishing to earn a baccalaureate in nursing.

Other primary sources used for this study include the archival records of the schools the women attended and the hospitals in which they worked. Secondary sources include selections in the history of feminism, nursing, and women in Canada and the United States, as well as literature related to the histories of professionalism, unionism, the family, and religion (see Appendix E: Sources).

Analysis and Theoretical Framework

Analysis of the interviews is attentive to the analytic categories of gender, race, class, and religion, and is informed by Foucault's concept of "governmentality." These concepts are discussed more fully in Chapter Two. The concept of governmentality is threaded throughout the analysis of the interviews and represents a way of interpreting key themes by critically examining the social, economic, and political context in which they are embedded. This concept provides a means of excavating, as Colin Gordon explains, the ways that certain "'techniques of power', or of 'power/knowledge', [are] designed to observe, monitor, shape and control the behaviour of individuals situated within a range of social and economic institutions such as the school, the factory and the prison."³⁸

The women interviewed for this study occupied many social, political, and economic positions in which various techniques of power shaped, and were shaped by, shifting discourses about women, nursing, work, marriage, motherhood, unionization, feminism, professionalism, and altruism. The regulation of these and other women's lives

³⁸ Colin Gordon, "Governmental Rationality: An Introduction," in *The Foucault Effect: Studies in Governmentality*, ed. Graham Burchell, Colin Gordon, and Peter Miller (Chicago: University of Chicago Press, 1991): 2–3.

through these discursive practices is expressed in terms of rules, regulations, working conditions, wages, standards of professionalism, as well as other formal and informal structures of social control that Foucault identifies as “the government of one’s self and of others.”³⁹ Examining the history of nursing using Foucault’s concept of governmentality is a means, as Cameron explains, “of coming to see, analyzing, the modes of thought that constitute our practices [in such a way] that what we accept as going without saying no longer goes without saying.”⁴⁰

Chapter Summaries

Chapter Two presents the research design, and methodology of this study, including a description of the participants, the position of the researcher, and the key analytic concepts of oral history, feminism, and governmentality. Chapter Three examines the social location and historical context of the research, including a brief history of nursing education in Canada and a description of the schools of nursing from which participants graduated. Chapter Four focuses on women’s attraction to nursing; what they found when they entered nursing school; the discursive practices that governed their experiences; and the decisions, opportunities, and challenges they faced upon graduation. In Chapter Five, I examine the how women combined work and motherhood and how women struggled to achieve a balance between work, marriage, and motherhood. The complexity of women’s changing social roles in these decades is presented with a focus on differences within the feminist movements, specifically between labour feminism and liberal second-wave feminism, which represented differing class interests in nursing. Chapter Six examines how, in these decades, what had been a

³⁹ Ibid., 2.

⁴⁰ Cameron, “Nursing and the Political,” 153.

mostly unified understanding of the concept of professionalism in nursing unravelled as front-line nurses sought support from unions for workplace demands, and nurses in management positions sought to replace an image of professionalism based on service, altruism, and bedside nursing skills with an image of professionalism based on academic credentials and desirable standards of individualism and autonomy. Chapter Seven presents a summary of the main arguments and contributions of this study in light of current issues and debates in nursing. In this way, I hope to create and disseminate new questions about the history of nursing in a way that will “further advance our understandings of the realm of politics and nursing, with a particular attention to the ways that [past] politics shapes the present state and the future of nursing practice.”⁴¹

⁴¹ Ibid., 154.

CHAPTER TWO

Research Design and Data Analysis

This chapter presents my research design and approaches to data analysis. Key elements of the research design include recruitment, sampling, the demographic questionnaire, ethics, risks and benefits of the research, key questions, and a profile of the researcher and participants. Key elements of data analysis method are oral history, feminism, and Foucault's conceptualization of governmentality.

Oral history interviews with thirty-seven women who entered nursing school between 1958 and 1977 form the primary data used in this study and are described in detail below. Other primary sources include documents from the schools of nursing that the interviewees attended, and other key documents related to the context of these women's lives as nursing students, nurses, wives, and mothers. Secondary sources include selections from the historiography of nursing, women, and work in post-war Canada, specifically the 1960s and 1970s.

Research Design

Recruitment

I created a recruitment letter that used accessible and transparent language to outline the research I was interested in conducting, and asked if the individual would be interested in participating in an audio taped interview in person or by phone (see Appendix B: Recruitment Letter). The recruitment letter provided my contact information in the event that individuals were interested or had questions or concerns. A letter outlining the research was e-mailed or mailed to potential participants. I used the same recruitment information when contacting individuals by phone or in person. Interview

data was organized around each School of Nursing location (Vancouver or Calgary), the year the interviewee started nursing school, the length of the program (three-, four-, or five-year program), and the year the interviewee graduated. Demographic data was also collected regarding each interviewee's marital status, number of children, level of education, and main area of work in nursing (see Appendix E: Demographic Questionnaire).

Sampling

Recruitment of participants was done through snowball sampling, a method commonly used in qualitative research studies. As Chaim Noy suggests, "When viewed critically, this popular sampling method can generate a unique type of social knowledge—knowledge which is emergent, political and interactional."¹ Mark Handcock and Krista Gile comment, however, that researchers have used the term "snowball sampling" inconsistently since it was introduced in the literature in the 1940s. Most recently, the term has come to refer to a form of convenience sampling for collecting a sample of information or experiences that might be missed by more standard sampling procedures.²

The sample I was drawing from consisted of graduates of nursing programs in the late 1950s to the mid-1970s, individuals who had since moved across the country and around the world. I knew that the majority of women who graduated in this period had spent at least three years living together continuously in a residential setting. Even the graduates of the University of British Columbia School of Nursing had spent a significant

¹ Chaim Noy, "Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research," *International Journal of Social Research Methodology* 11, no. 4 (2008): 327.

² Mark S. Handcock and Krista J. Gile, "Comment: On the Concept of Snowball Sampling," *Sociological Methodology* 41, no.1 (2011): 367-71.

amount of time living together in dormitory-type residences, in proximity to their diploma-based colleagues. I knew that these women would be roughly the same age, and also from similar backgrounds—for example, similar in cultural heritage, class (both working and middle class), religion, and gender. While I had the names of the schools of nursing in Vancouver and Calgary, I felt it would be too time consuming to track down these now mostly married women from the records of graduating classes, particularly because it was the custom then for women to change their surname upon marriage. I considered networks through which these women might have stayed in touch and learned that school alumni associations were still very active. Because alumni associations rely on the meaningfulness of shared experience, I knew that members who valued those experiences would probably be in touch in some way. Snowball sampling appeared to offer a way to leverage these relationships and to gain access to women who probably shared a common interest in their identity as nurses. As Noy explains, “Snowball sampling relies on and partakes in the *dynamics of natural and organic social networks* [italics in original].”³

There are difficulties with snowball sampling, however. It is important, Noy warns, to choose a sampling method carefully. This is because “sampling amounts to a crucial link in the research chain, which can undoubtedly ‘make or break’ research.”⁴ Noy claims that while snowball sampling is the most commonly used method of sampling in the social sciences, it is sometimes seen as an informal and possibly overly biased method of selecting participants. For example, choosing participants from alumni associations might select for women who had the resources to maintain connections, or

³ Noy, “Sampling Knowledge,” 329.

⁴ Ibid., 330.

who had a particular allegiance to preserving and projecting a specific image of nursing history.⁵ In addition, Noy explains, snowball sampling can be confused with other methods such as “chain, referral, link-tracing, respondent-driven and purposive sampling, which further contribute to the lack of integration and coherence of snowball sampling.”⁶ In fact, snowball sampling *is* similar to these methods. To clarify how I conceptualize this method, I draw on Noy’s definition:

A sampling procedure may be defined as snowball sampling when the researcher accesses informants through contact information that is provided by other informants. This process is, by necessity, repetitive: informants refer the researcher to other informants, who are contacted by the researcher and then refer her or him to yet other informants, and so on. Hence the evolving ‘snowball’ effect, captured in a metaphor that touches on the central quality of this sampling procedure: its accumulative (diachronic and dynamic) dimension.⁷

Noy’s argument that snowball sampling produces a unique kind of social knowledge is consistent with the kind of knowledge produced through oral history methods, as explained by Lynn Abrams later in this chapter.⁸ Although I used snowball sampling, I also wanted to achieve some diversity in the sample. Thus, I chose two sites—Calgary and Vancouver—and seven schools of nursing, including one university school, two Catholic denominational schools, and four residential-based programs leading to a diploma in nursing. Snowball sampling took place through a number of venues, including professional associations, newspapers, magazines, local historical publications, alumni organizations, and current schools of nursing located in Vancouver and Calgary. Potential recruits were sent a recruitment letter and a consent form and were

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Lynn Abrams, *Oral History Theory* (London: Routledge, 2010).

invited to contact me for further information (see Appendix C: Recruitment Letter and Consent Form).

Interview Processes

Demographic Questionnaire

Thirty-seven participants were interviewed, all of whom graduated from hospital- and university-based schools of nursing between 1958 and 1977. No men responded to my request to participate in this study. The total interview time was, on average, seventy-five minutes, including the demographic questionnaire, which was mailed or faxed, or scanned and discussed at the beginning of the interview. I asked to record each interview, which I audiotaped through a computer program at a time and location of the participant's choice. The majority were telephone interviews due to the diverse locations of the participants, or to their preference. The participants were not obliged to answer or respond to any questions or topics that they were not comfortable with. Consent for the interview and use of the data resulting from the interview analysis was obtained verbally and in writing (see Appendix C: Consent Form and Demographic Questionnaire).

Ethics

Interviews were transcribed verbatim and kept in a secure and locked location to which only I had access. Informed and ongoing consent, as well as assurances of confidentiality were provided in accordance with the precepts of the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans (see Appendix D: Ethics Approval). The nursing community in the 1960s and 1970s in Calgary and Vancouver represented a small population, and because of the limited number of institutions where women could obtain their education and employment and given the age

of participants now, it was possible that within a particular group of former students, members may have been able to identify each other through excerpts from the transcripts of each other's interviews. Also, the nature of snowball sampling could mean that participants were known to each other or to the researcher. For these reasons, I gave each participant a pseudonym for the purposes of including excerpts, from the interviews. Also, to give cohesion to the quotations, syntax, spelling, and grammar have been modified, and quotes may contain excerpts from differing parts of the same transcript. In one excerpt I have disguised particular identifying aspects of the story told, at the request of the interviewee.

The consent form stated that the confidentiality of the data would be preserved as much as possible under these circumstances by storing audiotapes and any printed transcripts in a locked cabinet in the researcher's office, and by storing typed information/transcripts in password-protected files on the researcher's work computer. I did not link the information from the demographic questionnaire to the transcripts of the audiotaped interviews. Only the researcher had access to the original data (see Appendix D: Ethics Approval).

Risks Associated with the Research

The participants told stories of their nursing education and early nursing careers in the 1960s and early 1970s in western Canada, specifically in Calgary and Vancouver. The risk of harm to individuals as a result of sharing their stories in an interview was expected to be no greater than the risk from describing their experience to friends and colleagues. While some participants might engage in reflection on events of their lives from an earlier period, it was expected that the risk of harm from this introspection would

be no more than would occur in their everyday lives. The consent form also stated that participants had the right to refuse to answer any questions or address any topics that they did not wish to address or that they did not feel comfortable answering or discussing (see Appendix D: Ethics Approval).

Benefits Of The Research

The potential benefits of participation in this study for the participants included the opportunity to share the joys experienced and the challenges faced during their early nursing education and career. They were also offered the satisfaction of knowing that sharing their experiences would enhance society's understanding of the profession of nursing and the role of women in society—particularly in the post-war period in western Canada.

Society could benefit from this research by gaining a greater understanding and appreciation of the educational and professional history of nursing, a profession that is of primary importance to society.

At a time when there are reduced numbers of nurses available to fill positions in nursing, it is vital that more nurses are attracted to, educated in, and absorbed into the profession. The role of nursing in today's Canadian context, and the historical and social factors that have both challenged and promoted the profession, reflect wider trends in women's work experience and social roles. This study will potentially contribute to a greater understanding of the role of women's labour, the impact of marriage and motherhood on women's labour, and the role of nursing in shaping current attitudes toward women's participation in the social and economic benefits of Canadian

citizenship. It also makes a contribution to the history of women's labour, Canadian history, and feminist history (see Appendix D: Ethics Approval).

Key Questions

Key questions asked in each interview were: Why did you desire to become a nurse? What was your experience of becoming a nurse in western Canada in the 1960s and early 1970s, and did your role as a woman at that time influence that experience? How did your role as a woman influence your experience of being a nurse during this time period? What other factors were significant in shaping your experience of being a nurse during this time period? What meaning do you now make of being a nurse during this time period? What questions about the experience of being a nurse during this time period have not been asked in this interview and are important for me to know about? Questions I wished I had asked included: What was your involvement with the union or labour movements at this time? Were you in favour of nursing education moving from the diploma, hospital-based programs to the college and/or university system? What were your feelings about your wage in comparison to the wages of men with similar educational preparation and/or responsibilities?

Profile Of The Participants

Information obtained from the demographic questionnaires revealed the following participant profile. In Vancouver, participants included nine graduates from UBC, three from St. Paul's Hospital School of Nursing, one from the Royal Columbian School of Nursing, and nine from the Vancouver General School of Nursing. In Calgary, there were four participants who graduated from the Holy Cross School of Nursing, one from the Foothills School of Nursing, and ten from the Calgary General School of Nursing. Thirty-

six of the thirty-seven women were between the ages of sixteen and nineteen when they entered nursing school; one was twenty years old. All graduated within three, four, or five years of entering their nursing program, depending on whether they attended a three-year diploma or a four- or five-year university degree program. All the women interviewed entered nursing school within two years following high-school graduation and were practising nurses within six years of that entry (see Appendix A: Table of Participants).

Analysis Of Interview Data

In this study, analysis of the interview data is guided by three methodological approaches: oral history, feminist analysis, and Foucault's conceptualization of governmentality.

Oral History

Kathryn Haynes explains that "oral history allows individual subjectivity and experience to be central to the empirical data."⁹ Nursing is a practice lived through relationships with others, and understanding the lived experience of the individual is central to the nurse's ability to promote and facilitate the well-being of the other. Similarly, oral history interviewing is a shared experience that occurs between individuals, with the interviewer having a particular purpose in mind for the interview. Further, according to Lynn Abrams, "The oral historian, broadly speaking, asks people questions to discover four things: what happened, how they felt about it, how they recall it, and what wider public memory they draw upon."¹⁰

⁹ Kathryn Haynes, "Other Lives in Accounting: Critical Reflections on Oral History Methodology in Action," *Critical Perspectives on Accounting* 21, no. 3 (2010): 221.

¹⁰ Abrams, *Oral History Theory*, 78.

Oral history is a methodological approach and scholars working in a number of research traditions and disciplines have produced a substantive body of knowledge about this method. Oral history is interdisciplinary in nature, drawing on methodologies from history, psychology, and sociology. In particular, oral history allows the narrator to reflect on the past within the context of the present. The narrator becomes a performer of, and in, his or her life-story.¹¹ Unlike written records, the text created from a verbal exchange between the narrator and the interviewer is the historical text. The interviewer as researcher has the freedom to express ideas and thoughts in a way that may not otherwise have been available in any other written form, and about subjects that have not traditionally been topics of historical research.¹²

These non-traditional topics include, as in this study, the lived experience of women's everyday lives. In oral history, there is no "script" to follow in conducting the interview. It is the interviewee's experience that is sought, in all its complexity, ambiguity, and possible contradictions. Rather than focusing on a grand historical event and asking the interviewee to comment on how she has been impacted by the event, it is the experience of the person being interviewed that is the focus of the interview.¹³ In the case of women who became nurses in the 1960s and 1970s, their personal experience of entering nursing, being a student in nursing, graduating, and making life choices after graduation is at the centre of the story. Social and historical events, such as the rise of the feminist movement and the increasing number of women in paid employment, provide a backdrop to these experiences. Much of the daily experience of how these broader social

¹¹ Valerie Raleigh Yow, *Recording Oral History: A Guide for the Humanities and Social Sciences* (Walnut Creek, CA: AltaMira Press, 2005).

¹² Ibid.

¹³ Abrams, *Oral History Theory*.

movements impacted the every day lives of “ordinary” women has not been recorded in historical documents.¹⁴

While Joy Parr claims that the practice of oral history is consistent with the historical practices of both gender history and women’s history,¹⁵ Kathryn Haynes warns that there are the same dangers in so-called ‘feminist’ research as there are in so-called ‘mainstream’ research. Haynes explains that “Feminist oral history research may have originated in a desire to refute ‘malestream’ interpretations of women’s lives, using ‘a method that enables the discovering of the social experiences of “silenced women”(or other silenced groups)’ ... However, many feminist researchers came increasingly to question the balance of power in relations between women researching other women, or the homogeneity of women as a universal category.”¹⁶ Thus, in this research, I was conscious that while I claimed the benefits of a feminist approach to the interviews, I needed to be cautious that “Sameness in gender does not override distinctions in class, race, religion, age, ablebodiedness, or ethnicity, or preclude significant differences in experiences”¹⁷ and thus consciously provide and create space to invite differences to be expressed.

In the oral history tradition, the interviewer and the interviewee co-participate in an interactive process through a single conversation, or in a series of conversations. A transcript of the interview is produced and then analyzed for meaning, paying attention to factors such as language structure, effects of time on past and present meaning, chronological structuring of the narrative, and social and historical context. The

¹⁴ Ibid.

¹⁵ Joy Parr, “Gender History and Historical Practice,” *Canadian Historical Review* 76, no. 3 (1995): f-27.

¹⁶ Haynes, “Other lives in accounting,” 224.

¹⁷ Ibid, 224.

interviewer is an active participant in creating the meaning that emerges through an analysis of the interview transcript, and thus brings her own particular biases and assumptions shaped by influences such as gender, race, class, culture, religion, education, and professional status.¹⁸

Memory

Haynes argues that oral history methodology as a tool of historical research has a long history. For Haynes, oral histories facilitate a description of “feelings, emotion, memory, perception and identity” over the lifespan.¹⁹ For some of the women interviewed, their early experiences as young women in nursing school occurred over fifty years ago, and yet all had stayed in touch to varying degrees with members of their early nursing communities. Becoming a participant in my research study was thus another means of sharing community and building social memory. As Haynes suggests, “Oral histories also facilitate connections between social groups and roles, giving insights into the lives of many, because the narrator weaves their story with those of significant others, such as children, parents, partners, employers and colleagues. As such, oral history exposes the life experiences of individuals, which more formal documentary sources may fail to elucidate.”²⁰

At the heart of this methodology lies memory. Memory and the process of remembering are central to oral history.²¹ In this study, interviewees were asked to recall events that occurred, for some, over fifty years earlier. Questions arising for analysis from the interview data included: How did women who became nurses, married, and

¹⁸ Gluck and Patai, *Women's Words*.

¹⁹ Haynes, “Other Lives in Accounting,” 221.

²⁰ Ibid.

²¹ Abrams, *Oral History Theory*, 78.

became mothers experience changes in the social construction of women's roles during the 1960s and early 1970s, particularly in Calgary and Vancouver? What were the major debates in feminism in Canada during the 1960s and early 1970s, and are these debates reflected in the choices and considerations nurses made in regard to work, marriage, and motherhood during this time period in the two cities? What are the significant intersections between the history of nursing, women, work, and motherhood in western Canada during the 1960s and early 1970s, as exemplified by changes in the social construction of nursing during that time period?

Much has been written about the "problem" of memory in oral history interviewing. From a quantitative research perspective, some writers have asked, "How reliable and valid is oral history?"²² In the 1970s, according to Alistair Thomson, critics of oral history questioned the reliability of people's memory, claiming that "memory was distorted by physical deterioration and nostalgia in old age, by the personal bias of both interviewer and interviewee, and by the influence of collective and retrospective versions of the past."²³ In contrast, Valerie Yow argues that there is no evidence that can resolve the question about whether oral history is a "reliable" source of information about particular events. For Yow, "human memory is both fallible and—when we approach the oral history document *critically*—trustworthy."²⁴ Further, Abrams emphasizes that it is important not to think of memory as simply a repository of facts; rather, it is a way of

²² Alistair Thomson, "Four Paradigm Transformations in Oral History," *The Oral History Review*, 34, no.1 (2006): 53.

²³ Ibid.

²⁴ Yow, *Recording Oral History*, 36.

making meaning. For Abrams, “memories are not pure; they are contingent. They are as much about the present as the past.”²⁵

Memory is constructed from both personal and collective contexts, which include the families and communities in which we live and the nation and world in which those communities are located. Memory is thus a personal and shared experience. While I asked each participant similar questions about their experience of nursing, their responses revealed both unique and similar personal experiences, which both conformed to and contradicted the narrative of a shared social memory as nurses. In this way, the interviews confirmed Abrams’ argument that “memory is the site of struggle for competing meanings.”²⁶ This struggle is evident in the ways interviewees reported incidents they say caused them a great deal of anxiety, even harm, at the time they occurred, and then reflected on the valuable lessons learned as a result of these incidents later as they became practising nurses.

Ethical considerations

In the interviews, I asked women about life experiences beginning with their early motivation to enter nursing. I also inquired about the influence of parents, friends, and family on making that decision, their experience of nursing education, early employment opportunities, and the transition to adulthood. Some women claimed that their reasons for entering nursing had not changed over time. For others, the story was more complex and ambiguous, symbolizing changes in attitudes toward gender, self, society, education, and their roles as nurses, wives, and mothers. In order to be sensitive to these differences, I followed the advice of Haynes, who warns that oral histories must be used “critically and

²⁵ Abrams, *Oral History Theory*, 79.

²⁶ *Ibid.*, 80.

reflexively.”²⁷ This reflexivity reminds the researcher to remain conscious of ethical issues around topics related to the interview process including vulnerability, sensitive personal issues, ownership of the narrative interpretation, and power imbalances or “reciprocity within the research relationship.”²⁸

Valerie Yow also discusses some ethical issues in oral history interviewing that were relevant to my research.²⁹ A critical and reflexive awareness of oral history methodology implies the acknowledgement of the inter-subjective nature of the relationship between the researcher and the person being interviewed, and the possible impact of differences between them. Thus, as a nurse and a woman close to the same age as my interviewees, it was relatively easy to establish a rapport based on a shared professional standing. We were women, we were of a similar age, and we shared something of a common social memory of the 1960s in western Canada. We might also assume that we shared a vision of nursing in which the role of nursing is to do good—leave the patient in the best possible condition to heal. However, as Yow explains, the assumption of commonality in the interview can also preclude important differences that might ultimately be of value to the research study. For these reasons, I was reflexively aware of the potential for obscuring difference or discouraging the expression of dissent during the question-and-answer dynamic of the interview.³⁰

While it was easy to build on the assumption of shared memory to establish rapport and gain entry into experiences that might otherwise be difficult to explain to a non-nurse, at the same time I was concerned that few nurses told me stories that did not

²⁷ Haynes, “Other Lives in Accounting,” 221.

²⁸ *Ibid.*, 221.

²⁹ Valerie Yow, “Ethics and Interpersonal Relationships in Oral History Research,” *Oral History Review*, 22, no.1 (1995): 51–66.

³⁰ *Ibid.*, 52.

conform to the ethic of “doing good” in nursing. I was worried that because such stories of “goodness” were prominent, introducing occasional contradictions might be perceived as “disloyalty” to nursing. As Linda Shopes reveals in her discussion of oral history and the study of communities, “a celebratory impulse also inflects many community interviews.”³¹ There are many reasons for this circumstance, including “the deeply social nature of oral historical inquiry: a community insider, interviewing a peer, does not want to risk disturbing an ongoing, comfortable social relationship by asking difficult or challenging questions.”³² The women I interviewed drew me into their shared community as a nurse, and the topics they covered with me explored the remembered terrain of that community. Shopes also contends that the space created within the interview may have different meanings for the interviewer and the interviewee. For the interviewee, the interview experience may create “a benign refuge from the unsettling present ... and interviews become a means of putting the community’s best face forward.”³³ While I hoped that I had provided the conversational space for discussing difficult or conflicting events, Shopes warns that “even when interviews probe difficult aspects of personal or social history, the impulse is to celebrate the interviewee’s ability to prevail over or survive difficult circumstances.”³⁴ For example, I questioned whether I should include an excerpt from a particular story that cast the nurse (and nursing?) in a very unfavourable light; yet this was an important story and one that illuminated prevailing negative attitudes toward certain racialized groups in Canada—nurses were not immune. The woman interviewed revealed this story as one whose outcome she later regretted, and the

³¹ Linda Shopes, “Oral History and the Study of Communities: Problem, Paradoxes, and Possibilities,” *The Journal of American History*, 89 no.2 (2002):591.

³² *Ibid.*, 591.

³³ *Ibid.*

³⁴ *Ibid.*

interview appeared to provide a space in which she could acknowledge this regret.

Nonetheless, it was her joy of nursing as a young woman that dominated the interview, not an analysis of racism in Canada in the 1960s, which was an issue I would have liked to explore in more depth with her in that interview.

Another point of commonality and difference that might have created tension between the interviewees and me related to educational credentialing. Although I was a nurse—and fortunately one who had graduated from a diploma school like the majority of my interviewees—my current status as an academic had the potential to create tension and resentment between us on certain topics, or at least to generate a guarded response to some questions about the value of diploma versus degree programs. I was aware that the women I interviewed had probably agreed to the interview because I was a nurse and they had assumed I was of the same age and background as them. In fact, I had *not* graduated from a hospital-based program but, rather, a college program, nor had I lived in nursing residence. While they were in their teens when they started nursing school, I was forty. I did not volunteer this information unless I was asked. At the same time, I did emphasize that I had received a diploma in nursing, had grown up in Vancouver, and had attended the University of Calgary—another common link to shared memory. And yet, there was complexity in the interviews, and after they were completed and I began to analyze them, I began to understand that within a shared “language” and even common vision of nursing, significant differences were present.

These differences are predictable. As Yow explains, there is no separation between the researcher and the person interviewed. Instead, there are “two people, each bringing a different kind of knowledge to the interview, [who] share equally in a process

of discovery.”³⁵ Inviting women to remember their early life in nursing allowed them to participate in providing a new interpretation of this period and challenge existing assumptions. Sharing memories served as the vehicle to communicate and authenticate these alternative insights. As Abrams asserts, “Memory then is ... the core of oral history practice. It is no longer just the source of oral history but the subject of what we do.”³⁶

The question of how meaning is made and shared over time is an important concept in this dissertation. While experiences might be shared, the meaning attributed to them by individuals may be very different between individuals, and may have changed over time.

Position of the Interviewer

Because the passage of time can change the meaning of past events, and even how and what is remembered, the interviewer must remember not to assume common meaning from common experiences. Students in nursing schools challenged “the rules” of their residential community, but at the same time they benefited from adherence to those rules and the *appearance* of being similar and conforming to dominant norms. The question of whether they actually *were* similar or *did* share common values, beliefs, and assumptions, or whether they were “forced” to appear and present themselves in particular ways, is an interesting topic for discussion. In my interviews, interviewees had the option to choose what experiences to reveal, but also what to conceal. As Gerald Creed asserts, it is examining each in relation to the other that forms the boundaries of a community, with degrees of tolerance for difference between members, but, at the same time, disciplining practices that create firm boundaries of exclusion.³⁷

³⁵ Yow, “Ethics and Interpersonal Relationships,” 53.

³⁶ Abrams, *Oral History Theory*, 78.

³⁷ Gerald W. Creed, *The Seductions of Community: Emancipations, Oppressions, Quandaries* (Oxford [UK]: School of American Research, 2006), 4.

Penny Summerfield maintains that the position of the interviewer is complex because the interviewer is embedded in the very discourses that she is trying to step outside of and observe. This dynamic creates the interplay between discourse and subjectivity, in which the interviewer is an observer and also, in analyzing the meaning of the interview, the observed.³⁸ According to Summerfield, there is no experience outside the discursive context in which it occurs, and thus a sense of objectivity or detachment on the part of the interviewer is essentially false.³⁹ During the interview process, the discourses I was conscious of and also immersed in were, in part, related to gender, religious orientation, cultural heritage, and age. What was different, I assume, between me and the women I interviewed was that, while I was conscious of these discourses, they probably assumed that our “shared” background created a shared understanding of the meaning of the events they were describing.

Finally, in oral history research, it is important for the researcher to be critically aware of analyzing the past through the lens of “presentism.”⁴⁰ Historians, according to Oscar Moro-Abadia, must be cautious of how they use their current knowledge of past events, and their knowledge of “what happened next,” to select which events and which lenses of analysis to employ in the interpretation of those events.⁴¹ Moro-Abadia refers specifically to the problems posed by presentism for historians of science, and here I include nursing. Moro-Abadia refers to Thomas Kuhn’s *Structure of Scientific Revolutions* (1962/1970), in which Kuhn warns that we must be aware of how knowledge

³⁸ Penny Summerfield, *Reconstructing Women’s Wartime Lives: Discourse and Subjectivity in Oral Histories of the Second World War* (Manchester, UK: Manchester University Press, 1998), 13.

³⁹ Ibid.

⁴⁰ Oscar Moro-Abadia, “Thinking about ‘Presentism’ from a Historian’s Perspective: Herbert Butterfield and Helene Metzger,” *History of Science* 47, no.1 (2009): 55.

⁴¹ Ibid.

is constructed for the purposes of maintaining, reflecting, and reinforcing present dominant norms or paradigms. Nursing, as an aspiring science, is subject to the values, beliefs, and assumptions embedded in the discourse of science. As Kuhn comments, in science, it is sometime confusing to sort out which came first, the claim to science or the claim to progress, “our present difficulty [is] to recognize that we tend to see as science any field in which progress is marked.”⁴² Or, I would argue, to promote the illusion of progress in order to qualify nursing as a discipline that is scientifically based.⁴³

In summary, the oral historian must keep in mind the influence of memory, ethical considerations, and how she herself is constituted and situated socially and historically in relation to the interviewee and the interview dynamic. Making meaning from the interviews brings together the intersecting influence of these factors, which must be critically appraised when the interviewer makes claims about experiences that are recalled in the interviews. For example, I argue that the experience of a nursing education, while governed by strict rules of conduct that reflected dominant social norms and values, provided a familiar code of social and moral control. I argue that women who entered nursing gained unusual advantages in comparison to other women from similar backgrounds, and that the women interviewed who became nurses, married, and bore children, were not passive bystanders, but instead actively engaged in leveraging their essential position within the health-care system to utilize and create sources of power, such as unionization and professionalization, to counteract and re-shape the terms of their employment and domestic realities. However, in making these claims I must remain critically aware, as Yow has claimed, of the influence of memory and, as Shopes has

⁴² Thomas S. Kuhn, *The Structure of Scientific Revolutions* (Chicago, IL: University of Chicago Press, 1962/1970).

⁴³ Kuhn, *The Structure of Scientific Revolutions*, 162.

warned, of the desire to create community and valorize the past, or, as Moro-Abadia warns, of the danger of inferring meaning about past events based on present discourses. In particular, according to Fox-Keller and Kuhn, the historian of science must be aware, and cautious, of the dominance of the narrative of progress in science.

Considering the influences cited above on the analysis of the interviews in this study, I must also be critically aware that the women interviewed may now feel empowered over the conditions of their lives in a way they did not, or could not, conceive of being in their early twenties, and this change in social position may have coloured how they interpreted intentions or results of actions at that period in their lives. Balancing marriage, motherhood, work, and activism may now appear easier or harder than it was at the time these events were prominent in their lives. The comradeship created by speaking to another nurse, such as myself, may have caused interviewees to highlight similarities between us rather than differences, which in turn would possibly lead to a different interpretation of the meaning of these events in the analysis of the transcripts.

Feminist Perspectives

Meaning changes over time, so too does the way feminist ideology is used to interpret women's experiences and how power is distributed within the social matrix in which women live. In fact, there is not now, and probably never has been, one agreed upon feminist ideology or interpretation of what feminism means. As Helen Longino suggests, "feminism is a family of positions and inquiries."⁴⁴ For Longino, feminist epistemologies and methodologies share some common purposes, however, such as acknowledging how gender influences social privilege and access to particular types of

⁴⁴ Helen Longino, "Feminist Epistemology," in *Epistemology*, ed. J. Greco and E. Sosa (Malden MA: Blackwell Publishing, 1999), 327.

power within society. Similarly, Cassandra Pinnick argues that a feminist epistemology “sets the relationships between knowledge and politics at the center of its account in the sense that it tries to provide causal accounts—to explain—the effects that different kinds of politics have on the production of knowledge.”⁴⁵ Joan Scott also suggests that there is no *one* feminist identity or definition of feminism, rather, in referring to the influence of gender in shaping feminist ideology, Scott explains that gender is but one axis of identity and oppression and that, “while ‘women’ historically has served to consolidate feminist movements, it has also made race, class, ethnicity, religion, sexuality, and nationality somehow secondary, as if these distinctions among us (and the hierarchical positioning that accompanies them) matter less than the physical similarities we share.”⁴⁶

Gender, however, continues to be a prominent influence in shaping feminist scholarship. Alice Kessler-Harris elaborates on the challenges of employing gender as a dominant category of analysis in labour history, as she interprets a particular form of feminism, that of labour feminism. Kessler-Harris claims that the aim of “gendering” labour history is not to eliminate class as a lens of analysis, but rather “to suggest some of the ways gender has functioned historically: in the formation of class, in the creation and maintenance of a labor force, in the cohesion or disintegration of community, and within the labor movement itself.”⁴⁷ How feminism is understood, and by whom, and how that understanding changes over time is an important consideration in this study because of the way feminists have promoted particular views about nursing. For the women interviewed, their position within the male-dominated medical community and the male-

⁴⁵ Cassandra L. Pinnick, “Feminist Epistemology: Implications for Philosophy of Science,” *Philosophy of Science* 61, no. 4 (1994): 648.

⁴⁶ Scott, “Feminist Reverberations,” 1.

⁴⁷ Alice Kessler-Harris, *Gendering Labor History* (Urbana: University of Illinois Press, 2006), 15.

dominated scientific community had particular implications to the ways that gender, work, and nursing were configured in these decades. Feminism as a popular movement was useful—it provided a rhetorical platform for expression and a way to theorize women’s oppression—but also dangerous because feminists used that same rhetoric and theorizing to critique nursing as women’s work.

While acknowledging the artificiality of claims that there were common themes that united the feminist movement in the 1960s and 1970s, for the purposes of this study I refer to the popularized metaphor of “waves” of feminist thought and action that imposes a chronological order linking feminists to major social, economic, and political events in Canada and the United States. Employing this framework, I further elaborate on the work of women’s labour historian Dorothy Sue Cobble, mentioned above, who makes distinctions between what many have termed the earlier “labour feminist” movement of the 1940s and 1950s and the later “second-wave” movement of the 1960s and 1970s.⁴⁸ In addition, the second-wave movement, according to Momin Rahman and Anne Witz, was not one ideological movement, but rather a term describing a number of overlapping and divergent ideologies, including radical, Marxist, socialist, and liberal feminism.⁴⁹

An overview of Cobble’s distinction between labour feminism and second-wave feminism is useful in creating a framework of analysis for the events described in the interviews. In particular, “liberal feminism,” or the ideology of women’s social, political, and economic equality with men, most often associated with white middle-class feminists, is highlighted in contrast to “labour feminism,” associated with the interests of

⁴⁸ Dorothy Sue Cobble, *The Other Women's Movement : Workplace Justice and Social Rights in Modern America* (Princeton [NJ] ; Oxford [UK]: Princeton University Press, 2004).

⁴⁹ Momin Rahman and Anne Witz, “What Really Matters? The Elusive Quality of the Material in Feminist Thought,” *Feminist Theory* 4 no. 3 (2003): 243-61.

working-class women.⁵⁰ A more detailed distinction between these two ideologies is presented below.

According to Cobble,⁵¹ labour feminists represented the voice and concerns of working-class employed women from the 1940s to the 1970s and focused on “issues such as equal pay, maternity leave, seniority, and inequalities in unemployment insurance.”⁵² Conversely, for some young liberal second-wave feminists, achieving workplace rights through unionization, signalled collaboration with the architects of women’s oppression—men in the form of the oppressive patriarchal practices supported through capitalism. From this perspective, “Equality for woman—free partnership with man—cannot be found in an unjust and exploitative [Capitalist] society.”⁵³ Cobble argues that the labour feminist movement of the 1940s and 1950s, in which working-class women organized to resist oppression in the workplace and obtain better wages and working conditions for women, has been unfairly subsumed under the banner of the later so-called second-wave feminist movement. For Cobble, labour feminism was not a precursor to the feminist movement of the 1960s but, rather, “was its own coherent, evolving, and vital variant of feminist reform.”⁵⁴ Cobble’s argument rests on her claim that the power of the women’s labour movement built on Progressive and New Deal era (1890–1940) social feminist gains. She explains that social feminists “believed that women’s disadvantages stemmed from multiple sources and that a range of social reforms was necessary to

⁵⁰ Cobble, *The Other Women’s Movement*.

⁵¹ Cobble quoted in Joan Sangster, “Radical Ruptures: Feminism, Labor, and the Left in the Long Sixties in Canada,” *American Review of Canadian Studies* 40, no. 1 (2010): 3.

⁵² Sangster, “Radical Ruptures,” 1.

⁵³ Brief submitted to the government’s Royal Commission on the Status of Women, from the League for Socialist Action/Ligue Socialiste Ouvrière—April 1968.

⁵⁴ Eileen Boris, “Roundtable”: 58.

remedy women's secondary status."⁵⁵ Cobble claims further that, building on women's involvement in labour movements during these earlier times, labour women in the 1940s advanced the gains of the older social feminism to demand women's equal access to the benefits of economic citizenship.⁵⁶ Central to this goal was achieving the right for all women to "market work" and, importantly, to secure, "social rights, or the social supports necessary for a life apart from wage work, including the right to care for one's family."⁵⁷

Building on the themes of labour feminism presented above, and with respect to the themes explored in the interviews, the desire of working-class and middle-class young women to enter nursing can be seen, in relation to the labour feminist movement, as an expression of women's continuing demand for the right to participate in waged labour and simultaneously to expect workplace accommodation that would support their important social function as wives and mothers. Women in the 1960s and 1970s, including nurses, were increasingly demanding parallel workplace benefits to men, including pensions, seniority, disability income, health insurance, and for women in particular, maternity leave. A career in nursing provided the opportunity for women to establish themselves as workers, and their essential position within the burgeoning health care system gave them leverage as women and workers to place demands on employers for gendered workplace accommodation such as maternity leave, and retained seniority for parental leave, as well as higher wages and better working conditions. Nursing offered young women, not only from working-class backgrounds, access to paid employment. In addition, a university education afforded middle-class families the

⁵⁵ Dorothy Sue Cobble, *The Other Women's Movement: Workplace Justice and Social Rights in Modern America* (Princeton, NJ: Princeton University Press, 2004), 3–4.

⁵⁶ *Ibid.*, 4.

⁵⁷ *Ibid.*

opportunity to educate daughters in a way that would maximize their social status as professionally educated women and possibly create opportunities for upward social mobility. In these decades, a university education was promoted by liberal second-wave feminists, such as those heading the Royal Commission on the Status of Women, as providing ‘more’ equal access to social status and a bid for professional opportunities associated with male dominated professions.

While it is meaningful to appreciate a feminist perspective in relation to gender, it is also important not to make gender the only lens of analysis in relation to events in nursing history. Kathryn McPherson has identified the influence of gender, but also class, and ethnicity (and I would add race and religion), as defining the major social and political positions in which nursing unfolds.⁵⁸ As McPherson argues, “The mutual, if not always equal, influences of class, gender, and ethnicity need to be considered together in order to explain nurses’ position within the health-care systems and to understand nurses’ strategies to improve that position.”⁵⁹ Thus, a feminist perspective that includes the intersecting influences of gender, race, class, religion, *and* culture are central to this analysis.

Some feminist scholars have identified an approach to feminism that considers the intersecting influences of multiple axis of identity as an intersectional approach. As Sirma Bilge has argued, a feminist intersectional perspective does not privilege any one of “the great axes of social differentiation [such as] gender/sex, class, race, ethnicity, disability and sexual orientation [but instead] postulates their interplay in the production

⁵⁸ McPherson, *Bedside Matters*.

⁵⁹ *Ibid.*, 9.

and reproduction of social inequalities.”⁶⁰ In other words, social differences are not discrete, and their meaning and influence on the experience of individuals and groups is always contingent on time and place. Thus, an intersectional perspective allowed me to gain a deeper understanding of how the lived experience of women’s lives is both personal and contextual, and both subjectively and discursively shaped by shifting and overlapping markers of identity that include, but are not defined by, differences such as race, class, gender, religion, and culture. In addition, an intersectional approach acknowledges those markers of identity that can predict the nature of an experience, but also allows for responses that may be entirely contradictory or appear to be ambiguous when considering an expected position in relation to a particular category of difference. For example, if a particular woman as a nurse claims to be a feminist, how does she claim equality with male physicians as professional colleagues, but at the same time, rise from their chairs as a male physician entered the room? How did diploma-educated women as nurses, who identified themselves as working-class women, simultaneously claim to be professionals; a claim which was increasingly made by their largely middle-class degree educated colleagues?

Governmentality

My final methodological approach is informed by the work of Michel Foucault. Foucault uses the term “governmentality” to describe those interacting historical processes whose complex web of actions and effects are directed at the maintenance of a particular social order.⁶¹

⁶⁰ Sirma Bilge, “Recent Feminist Outlooks on Intersectionality,” *Diogenes* 57, no. 1 (2010): 58.

⁶¹ Michel Foucault, “Governmentality” in *The Foucault Effect: Studies in Governmentality*, ed. Graham Burchell, Colin Gordon, and Peter Miller (Chicago: The University of Chicago Press, 1991).

The concept of power is central to understanding how governmentality works as an instrument of social control. For Foucault, power is always relational and circulates in all directions; it is not merely a force for top-down oppression. Power is an instrument used by and upon individuals that has effects on both the individual and society. As Dave Holmes and Denise Gastaldo explain, power operates through networks of organization, communication, and relationships.⁶² As power is exercised upon individuals, they in turn exert power on others. As Holmes and Gastaldo explain, “nurses constitute and make feasible the institutions and systems that they believe are the source of their oppression.”⁶³ For example, resistance and conformity to the rules and regulations that governed those in residence, allowed nursing students to enjoy the privilege of living away from home, taught them the expected norms of their gender and profession, and also expanded to include opportunities for comradeship and shared social experiences through individual and group resistance to largely benign forms of authority.

In summary, in relation to the major themes explored in this study and Foucault’s conceptualization of the exercise of power through processes of governmentality, students in the nursing school residences conformed to and resisted the governing discourses the processes which enforced in order to achieve their desired goal—to become a registered nurse. As working married women with children, nurses conformed to and resisted gendered discourses of the suitability of nursing as women’s work in order to claim status of valued professionals, but at the same time, championed their right to form labour unions in order to achieve workplace accommodation for their

⁶² Dave Holmes and Denise Gastaldo, “Nursing as Means of Governmentality,” *Journal of Advanced Nursing* 38, no. 6 (2002): 557-565.

⁶³ Dave Holmes and Denise Gastaldo, “Nursing as Means of Governmentality,” *Journal of Advanced Nursing* 38, no.6 (2002): 558.

responsibilities as wives and mothers against the advice or consent of their professional organizations.

CHAPTER THREE

Context of the Study

In this chapter, I present a broad overview of the social, political, and economic context of women's lives in post-war Canada, specifically the 1960s and 1970s. This overview focuses on governing discourses influencing the education and practice of nursing, including caring, religion, service, the state, and feminism. The history of nursing education in Canada, and in Alberta and British Columbia more specifically, provides the social and historical context for a history of each of the schools of nursing from which interviewees graduated.

Post-war Canada

The historiography of working- and middle-class women's lives in the post-war period is contradictory. While historians of the women's movement and women's labour history in the 1960s and 1970s, including Sue Morgan, Dorothy Sue Cobble, and Alice Kessler-Harris,¹ suggest that women's greater participation in paid employment following the war was a result of women filling vacancies during the war, other historians, such as Ruth Pierson and Nancy Christie, have argued that although women took up paid employment during the war, the participation of women in traditional male activities such as manufacturing was promoted only as a temporary measure, not designed to challenge gender norms.² Pierson explains that, for example, to ensure gender norms, women doing work traditionally done by men were carefully portrayed wearing

¹ Sue Morgan, "Theorising Feminist History: A Thirty-Year Retrospective," *Women's History Review* 18, no. 3 (2009): 381–407; Dorothy Sue Cobble, *The Other Women's Movement: Workplace Justice and Social Rights in Modern America* (Princeton, NJ: Princeton University Press, 2004); Alice Kessler-Harris, *Gendering Labor History* (Urbana: University of Illinois Press, 2006).

² Ruth Roach Pierson, *They're Still Women After all: The Second World War and Canadian Womanhood* (Toronto: McClelland and Stewart, 1986); Nancy Christie, *Engendering the State: Family, Work, and Welfare in Canada* (Toronto: University of Toronto Press, 2000).

uniforms that emphasized the feminine form, in an attempt to alleviate public concern about women becoming too masculine.³ Pierson concludes that, “The war's slight yet disquieting reconstruction of womanhood in the direction of equality with men was scrapped for a full-skirted and redomesticated post-war model, and for more than a decade feminism was once again sacrificed to femininity.”⁴

As Mona Gleason and Jane Helleiner explain, there was widespread concern about the impact on the family of disrupted gendered norms and relationships in the post-war period. Government authorities feared that social unrest would result if the family unit—the heterosexual married adults and their biological children—did not prevail as the dominant social unit.⁵ Gleason further explains that “Canadian society, the experts warned, was paying a high price for a modern way of life in the form of rising divorce rates, juvenile delinquency, increases in the number of married women in the workforce, and general anxiety about the threat of communism and nuclear annihilation as the Cold War loomed.”⁶

“Canadian society” in the post-war period was dominated by the cultures and traditions of white, Christian, European immigrants and settlers.⁷ This dominance was reflected in patriarchal systems of governance embedded in health care, industry, government, education, and the military that reflected those cultures and traditions.⁸

³ Ruth R. Pierson, *They're Still Women*.

⁴ *Ibid.*, 220.

⁵ Mona Gleason, “Psychology and the Construction of the ‘Normal’ Family in Postwar Canada, 1945–60,” *Canadian Historical Review*, 78, no. 3 (1997): 442–477; Jane Helleiner, “‘The Right Kind of Children’: Childhood, Gender and ‘Race’ in Canadian Postwar Political Discourse,” *Anthropologica* 43, no. 2 (2001): 143–152.

⁶ Gleason, “Psychology and the Construction of the ‘Normal’ Family,” 443.

⁷ Franca Iacovetta, “Recipes for Democracy? Gender, Family, and Making Female Citizens in Cold War Canada,” *Canadian Woman Studies* 20, no. 2 (2000): 12–21.

⁸ Lance W. Roberts, *Recent Social Trends in Canada, 1960–2000* (Montreal: McGill-Queen’s University Press, 2005); James William Opp and John C. Walsh, *Home, Work and Play: Situating Canadian Social*

Likewise, the demographic profile of nurses in the 1960s and 1970s reflected a similar cultural, religious, and racial profile.⁹ Within this period, however, gender patterns began to shift in the broader society, and in nursing, more married women with children were likewise remaining in the paid labour market for longer periods.

In the immediate post-war era, 1945 to 1955, mainly working-class women worked for pay, but Doug Owram explains how the abundance of consumer goods, demand for female service-industry workers, and increasing enrolment of women in post-secondary education gradually influenced and changed attitudes toward middle-class women and paid employment.¹⁰ In relation to these trends, in 1950, “approximately 3,700 women graduated from university. By 1963 that number had tripled and by 1970 it had gone up sevenfold.”¹¹ Further, in the mid-1950s, less than a quarter of women between the ages of twenty-five and forty-four were employed outside the home. “By the mid-1960s, the figure was about one-third and by the mid-1970s nearly one-half.”¹² At the same time, the birth rate declined and there was a tendency for women to have children later in life, meaning that women could stay in school longer, work, or delay marriage and childbearing against the norms of previous generations. These changes gradually undermined the solid foundations of the cult of domesticity and unpaid caregiving. It did not, however, guarantee gender equality.

Gender inequality became a national concern to the dominant class, influenced by

History, 1840–1980 (Toronto: Oxford University Press, 2006); Mridula Nath Chakraborty, “Constructing the Canadian Citizen,” *Herizons* 22, no. 2 (2008): 53-55.

⁹ Catherine Ceniza Choy, “Nurses Across Borders: Foregrounding International Migration in Nursing History,” *Nursing History Review* 18 (2010): 12–28; Karen Flynn, “Beyond the Glass Wall: Black Canadian Nurses, 1940–1970,” *Nursing History Review* 17 (2009): 129–152.

¹⁰ Doug Owram, *Born at the Right Time: A History of the Baby-Boom Generation* (Toronto: University of Toronto Press, 1996).

¹¹ *Ibid.*, 274.

¹² *Ibid.*, 276.

the rise of the feminist and civil rights movements in the United States.¹³ The report of the Royal Commission on the Status of Women, for example, which included data from the Department of National Revenue 1967 income tax year, emphasized that women earned only one-fifth, or 20.6 percent of the total combined income for men and women based on wages and salary income.¹⁴ Owram argues, however, that it was not income inequality that women protested. Rather, Owram contends, it was the lack of opportunities for educational equality and the unequal access to opportunities arising from the economic boom of the post-war period that promised advancement economically and in terms of social status. According to Owram, women born after the war were better educated than any previous generation of Canadian women, and their rising expectations for equal access to the benefits of social and economic citizenship drove social change in these decades. Owram claims, “The very fact that they were better educated and had higher expectations explains much about the demands that were about to develop.”¹⁵ Embedded in the protest over women’s limited access to education, income, and social power was a challenge to the assumption that men had a more legitimate claim to higher education, and that women naturally occupied a lower level of social, political, and economic influence.

Governing Discourses

Caring

In a study of Florence Nightingale’s legacy, Sioban Nelson argues that nursing

¹³ Barbara M. Freeman, “The Media and the Royal Commission on the Status of Women in Canada, 1966–1972,” *Resources for Feminist Research* 23, no. 3 (1994): 3.

¹⁴ Royal Commission on the Status of Women in Canada and Florence Bird, *Report of the Royal Commission on the Status of Women in Canada* (Ottawa: Information Canada, 1970), 22.

¹⁵ Doug Owram, *Born at the Right Time*, 274.

was, and still is, perceived by many as a form of altruistic service, an act that confirms women's natural ability to care.¹⁶ Susan E. Anthony and Janet Landeen explain that caring in the post-war period was considered “a feminine ontology requiring no particular knowledge.”¹⁷ In other words, for women, “caring” was a natural way of “being” a woman. Caring as women's work, and the assumption of women's subservience to men, led to the popular image of nurses as “handmaidens of the physician,” carrying out doctor's orders without questioning the social construction of these gendered roles.¹⁸

The idea of caring as an innate characteristic of women has also been reified in Christian traditions. Nightingale, who claimed to have been called by God to establish and reform nursing, did not advocate a direct role for religion in nursing, but she did employ assumptions about the role of women in a Christian society to reinforce the role of nurses in caring for the sick.¹⁹ As Alice Baumgart and Rondalyn Kirkwood contend:

Nursing fitted itself admirably into the natural division of labour between [Christian] women and men. The functions of motherhood had always included nurturing and caring for the sick and helpless, providing the moral and spiritual guidance for the young, and organization, management and cleanliness within the household ... nursing offered women an

¹⁶ Sioban Nelson and Anne Marie Rafferty, *Notes on Nightingale: The Influence and Legacy of a Nursing Icon* (Ithaca, NY: ILR Press, 2010).

¹⁷ Susan E. Anthony and Janet Landeen, “Evolution of Canadian Nursing Curricula: A Critical Retrospective Analysis of Power and Caring,” *International Journal of Nursing Education Scholarship* 6, no. 1 (2009): 1–14.

¹⁸ For a fuller discussion of the gendered relationship between nurses and physicians, see: Barbara Melosh, *The Physician's Hand: Work, Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987); Patricia E. B. Valentine, “Nursing: A Ghettoized Profession Relegated to Women's Sphere,” *International Journal of Nursing Studies* 33, no. 1 (1996): 98–106; Keith Cash, “Social Epistemology, Gender and Nursing Theory,” *International Journal of Nursing Studies* 34, no. 2 (1997): 137–143; Susan Gelfand Malka, *Daring to Care: American Nursing and Second-Wave Feminism* (Urbana: University of Illinois Press, 2007).

¹⁹ Lance W. Roberts, *Recent Social Trends in Canada, 1960–2000* (Montreal: McGill-Queen's University Press, 2005). The view that religion—specifically Christianity—formed the hegemonic matrix of moral, legal, political, and economic decision making at both public and private levels of social organization in the 1960s and early 1970s has been supported by Roberts, who reports that in a 1961 Gallup poll, 93.3 percent of Canadians reported being a member of a major Christian denominational church; in 1971, this figure had only dropped to 89.5 percent

opportunity to utilize women's natural skills within a wider sphere [of society].²⁰

In the post-war period, Christian traditions held that women had special knowledge about caring and a natural ability to care for others that was directly ordained by God.²¹ As Ellen Baer has argued, nursing exemplified Christian traditions of women's natural ability to care. Baer explains that the ideal nurse exemplified, "certain personal qualities and quasireligious ideas: kindness of heart, cheerfulness, a love of the work, a willingness to be 'on call,' and a desire to alleviate suffering—all without consideration of remuneration."²² This kind of selfless caring required a willingness to obey orders within a hierarchical structure that emphasized male power and authority, and the unambiguous expectation that the nurse would care for her patients above herself. For the majority of nurses in the first half of the twentieth century, this obedience to authority and undivided loyalty was best achieved through the services of the unmarried nurse, who did not have competing obligations and childcare responsibilities.

Religion and Caring

Members of female religious orders cared not only for the sick, but also for all members of their parish and those in need.²³ These women were the first formal nurses under colonial rule in Canada. It was the Grey Nuns in the seventeenth century, as well as Jeanne Mance in Quebec between 1642 and 1653, who organized nuns and laywomen to

²⁰ Alice J. Baumgart and Rondalyn Kirkwood, "Social Reform Versus Education Reform: University Nursing Education in Canada, 1919–1960," *Journal of Advanced Nursing* 15, no. 5 (1990): 511.

²¹ Mary Field Belenky, *Women's Ways of Knowing: The Development of Self, Voice, and Mind* (New York: Basic Books, 1986); Roberts, *Recent Social Trends in Canada*.

²² Ellen D. Baer, "'Do Trained Nurses...Work for Love, Or Do They Work for Money?'" *Nursing and Altruism in the Twenty-First Century*, *Nursing History Review* 17 (2009): 30.

²³ Susan Reimer-Kirkham, "Lived Religion: Implications for Nursing Ethics," *Nursing Ethics* 16, no. 4 (2009): 406-17.

care for the sick.²⁴ Brigitte Violette asserts that “the genesis of a large part of the hospital network in Quebec and, indeed, across Canada cannot be separated from the history of female religious orders.”²⁵

Canadian nurses were part of the missionary and colonial project that spread the reign and rule of Christianity throughout Canada. According to John Gascoigne, “From very early in its history, Christianity drew support from the structures of empire [and] ... provided a network of communications which greatly facilitated its dissemination.”²⁶ Gascoigne explains that the message of Christianity, transported by ships, roads, railways, and the written word, went hand in hand with the spread of empire. As Christie and Gauvreau explain, Christianity acted as a form of social authority and provided a list of acceptable and taboo behaviours for both men and women: “Religious ideas functioned, until at least the 1960s, as an authoritative cultural resource appropriated both by dominant social groups and by the disenfranchised—such as women, Aboriginal peoples, and workers.”²⁷ Christian traditions emphasized women’s obedience and service to God, the family, and the state and were pervasive in Canadian society in the post-war period. Nursing was steeped in these traditions.²⁸

²⁴ Brigitte Violette, “Healing the Body and Saving the Soul: Nursing Sisters and the First Catholic Hospitals in Quebec (1639–1880),” in *On all Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne E. Dodd, and Nicole Rousseau (Ottawa: University of Ottawa Press, 2005), 57-71.

²⁵ *Ibid.* 57.

²⁶ John Gascoigne, “Introduction: Religion and Empire, an Historiographical Perspective,” *Journal of Religious History* 32, no. 2 (2008), 160.

²⁷ Nancy Christie and Michael Gauvreau, “Modalities of Social Authority: Suggesting an Interface for Religious and Social History,” *Social History/Histoire Sociale* 36, no. 71 (2003): 3.

²⁸ Dianne E. Dodd and Deborah Gorham, *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Ottawa: University of Ottawa Press, 1994); Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing 1900–1990* (Toronto: Oxford University Press, 1996); Diana Jean Mansell, *Forging the Future: A History of Nursing in Canada* (Ann Arbor, MI: Thomas Press, 2004).

Service

The Canadian government and the Canadian Nurses Association emphasized nursing as one way that women could support Canada's war effort in the 1940s.²⁹ As Cynthia Toman explains, "Many nursing sisters referred to their participation in the war in terms of patriotism, with pride and acceptance of the militarization of care as both productive and normal."³⁰ The idea of the nurse (female) caring for the soldier (male) did nothing to disrupt gendered norms, despite the fact that nurses in the Second World War were officers and soldiers.³¹ While the image of women in the battlefield was inconsistent with gendered assumptions about women and combat, this resistance was overcome, according to Cynthia Toman, by conveying the importance of nurses' role in "caring" for Canadian male soldiers.³² During the war, these Nursing Sisters had benefited from the government's health and benefits package for enlisted officers, and following the war, these women launched a critique of the wages and working conditions of civilian nurses.³³ Their protests and lobbying played an important part in establishing the potential for labour organizing among hospital nurses in later decades.³⁴

The State

Following the Second World War, the resignation of many wartime nurses contributed to the shortage of nurses in post-war Canada.³⁵ Simultaneously, the demand for nurses then accelerated due to the rise of the welfare state and the funding of universal

²⁹ Cynthia Toman, *An Officer and a Lady: Canadian Military Nursing and the Second World War* (Vancouver: UBC Press, 2007).

³⁰ *Ibid.*, 117.

³¹ *Ibid.*

³² *Ibid.*

³³ *Ibid.*

³⁴ Janet C. Ross Kerr, "Milestones in Canadian Nursing History," *Journal of Professional Nursing* 8, no. 3 (1992).

³⁵ Toman, *An Officer and a Lady*.

health care. The construction of hospitals, staffed by student nurses who worked for no pay and by cheap graduate and supervisory nursing staff, made it possible for physicians to care for more people in a centralized location at an affordable cost. Physicians promoted hospital care as safe, modern, and progressive, and nurses as efficient and capable caregivers.³⁶ In fact, nursing care became indispensable to the delivery of health care. Skilled nurses played a vital role in the development of the emerging Canadian health-care system; a shortage of nurses could hobble health-care delivery. Nurses' assumed selflessness and willingness to "serve" under physicians for low wages contributed to the vitality and viability of the new publicly funded health-care system.³⁷ As Janet Ross-Kerr has noted, "Nurses were expected to work for little remuneration—in other words to subsidize the operation of the hospital almost as volunteers."³⁸

In addition to hospital building, funding for the welfare state included a substantial state investment in education and post-secondary institutions and in the provision of "social services" by other "helping" professionals.³⁹ Nurses were part of, and essential to, this expanding state and public sector investment in professionalization and the institutions that supported it. As demands for "professionals" and other specialized workers increased, the prestige of specialized education and training, including nursing education, also increased.

³⁶ Michael Bliss, "Contrary History: Socialized Medicine and Canada's Decline," *Canadian Medical Association Journal / Journal de l'association medicale Canadienne* 177, no. 2 (2007): 224;; Rosemary Ruth Gagan and David Paul Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950* (Montreal/Kingston: McGill-Queen's University Press, 2002); Joan Scott Matthews and Lynda Erickson, "Welfare State Structures and the Structure of Welfare State Support: Attitudes Towards Social Spending in Canada, 1993–2000," *European Journal of Political Research* 47, no. 4 (2008): 411–435.

³⁷ Janet C. Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta, 1859 to 1996* (Edmonton: University of Alberta Press, 1998).

³⁸ *Ibid.*, 25.

³⁹ Bryan D. Palmer, *Canada's 1960s: The Ironies of Identity in a Rebellious Era* (Toronto: University of Toronto Press, 2009); Kathleen Lynch and John Baker, "Equality in Education: An Equality of Condition Perspective," *Theory and Research in Education* 3, no. 2 (July 2005): 131–164.

Feminism

Mainstream feminism in the 1960s and early 1970s, has been theorized by feminist scholars to include a number of perspectives. A unifying assumption across these perspectives is that women in Western society are oppressed within patriarchal systems of social, political, and economic power.⁴⁰ In this view, gender is seen as a duality, and women are presented as oppressed by men. Class, however, as discussed above, is an important signifier of identity and meaning in this study, particularly in relation to my argument that divisions emerged within nursing between working-class and middle-class interests. These divisions, as will be presented in later chapters, took the form, most prominently, as tensions between unionization and a new conceptualization of professionalism based on academic credentialing. Class, along with gender, according to feminist labour historians Ava Baron and Alice Kessler-Harris, must be considered in any assessment of the relationship between gender and oppression.⁴¹ According to Baron, women's labour experiences differ from men's, but simultaneously, class divisions between working- and middle-class women make the experience of work different within categories of women workers.⁴² Within nursing, the interests of both working- and middle-class women to the right to paid employment were advanced to some degree because of the increasing acceptance of married women in the paid labour force, simultaneously, class divides between working- and middle-class nurses increasingly restricted the career opportunities of the former based on educational credentialing; access to a university degree was more easily obtainable women from middle-class

⁴⁰ Joan W. Scott, "Feminism's History," *Journal of Women's History* 16, no. 2 (2004): 10–29.

⁴¹ Ava Baron, *Work Engendered: Toward a New History of American Labor* (Ithaca: Cornell University Press, 1991); Kessler-Harris, *Gendering Labor History*.

⁴² Kessler-Harris, *Gendering Labor History*.

backgrounds.

Nursing Education in Canada

According to Kathryn McPherson, how nurses are educated determines the work they do, the conditions under which they work, and who can call themselves a nurse.⁴³ In the 1960s and 1970s, a young woman's orientation to caring, service, religion, the state, and the acceptable role of women began in childhood. Children and young girls were oriented to particular feminine roles through discourses that encouraged a particular expression of femininity and discouraged deviation. As young women entered nursing school, these norms were the basis of their instructive traditions.

Beliefs about the submissiveness of women and their natural tendency to be obedient to authority laid the foundations for the rules and regulations of training schools established toward the end of the nineteenth century.⁴⁴ Consistency and uniformity between training programs, resulting in a standardized set of nursing skills, became the desired outcome. These training programs gave rise to hospital-based schools of nursing, where students worked as apprentices and on graduation could call themselves "trained" or "graduate" nurses.⁴⁵ Barbara Keddy and Dianne Dodd explain that students were chosen from "respectable classes and from English- or French-speaking women."⁴⁶ Students were "supervised by a few graduate nurses, the students worked strenuously, 12 to 14 hours a day, were paid a meagre allowance of \$8-10 per month and were exposed to

⁴³ Kathryn McPherson, "Issues in Nursing Undergraduate Education," in *Realities of Canadian Nursing*, ed. Marjorie McIntyre and Carol McDonald (Philadelphia: Lippincott Williams and Wilkins, 2010).

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Barbara Keddy and Dianne Dodd, "The Trained Nurse: Private Duty and VON Home Nursing (Late 1800s to 1940s)," in *On All Frontiers*, ed. Dodd, Dianne E., Nicole Rousseau, and Christina Bates (Ottawa: University of Ottawa Press, 2005), 44.

dangerous contagious diseases on wards. Indeed, many historians describe them as exploited, oppressed, and usually exhausted.”⁴⁷

Hospital-based Programs

Hospital-based programs were the mainstay of nursing education from the early twentieth century into the 1970s, and student nurses were the backbone of hospital care.⁴⁸ Students worked long hours for little and often no pay in exchange for room, board, and tuition. Kathryn McPherson explains that well into the 1960s, women had limited access to university education, and for those in rural areas in particular, where there were very limited opportunities for female employment, training as a nurse in a big-city hospital “cost only a modest tuition fee (usually \$25 plus a small cost for the uniform), offered a small monthly stipend (which meant that students did not have to rely on their families for spending money), and provided residence accommodation.”⁴⁹ This was a time when young single women from respectable homes did not often live away from their parents, so their life in the residence was chaperoned.⁵⁰ As a result of the hospital-based programs’ success in attracting suitable young women, “nursing joined teaching and secretarial work at the pinnacle of the hierarchy of female-dominated occupations.”⁵¹

Nursing Education in Vancouver and Calgary

Nursing Education in Vancouver

In Vancouver, the schools of nursing from which participants were drawn were the UBC School of Nursing, St. Paul’s Hospital School of Nursing, the Vancouver

⁴⁷ Ibid.44.

⁴⁸ Suzanne Gordon, “Profits and Prejudice: The Undervalued Work of Nursing,” *Dollars & Sense* no. 231 (2000): 26-38.

⁴⁹ Kathryn McPherson, “The Nightingale Influence and the Rise of the Modern Hospital,” in *On All Frontiers*, ed. Dodd, Dianne E., Nicole Rousseau, and Christina Bates (Ottawa: University of Ottawa Press, 2005),82.

⁵⁰ Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999).

⁵¹ McPherson, “The Nightingale Influence,” 83.

General Hospital School of Nursing, and the Royal Columbian Hospital School of Nursing.

Three of these schools (and six of the seven schools from which participants for this study were drawn) offered three-year diploma programs exclusively. The fourth school, the UBC School of Nursing, opened in 1919 in Vancouver and offered four-, five-, and six-year programs leading to a baccalaureate in nursing. The UBC School of Nursing offered students the opportunity to specialize in one of three main areas of nursing practice—education, administration, or public health. Specialization generally occurred in their final year in the program. University students received classroom education and clinical time in their specialty area of choice. Students were not required to live in nursing residences, but many of them did spend time in residences, along with diploma students, during the clinical portion of their training. All diploma programs required students to be unmarried when they entered nursing school and to remain unmarried throughout their training; over time, this rule was relaxed according to individual circumstances.

During the period under study, the 1960s and 1970s, changes were taking place in nursing education in British Columbia. Hospital boards were reluctant to give up control over, and use of, valuable student labour in exchange for the lower cost of tuition, room and board provided by the residential hospital-based programs. In 1966, the Council of Hospitals and Schools of Nursing was established. Drawing on the recommendations of the 1932 Weir Report, which had recommended that nursing education be removed from control of hospital boards, this council again recommended that the education of nurses should be part of the post-secondary school system and that schools of nursing “should be

governed by independent boards of directors, responsible to the appropriate branch of the education system, and should be part of a regional college where possible.”⁵² At this time, the British Columbia Institute of Technology (BCIT) also opened, with a two-year nursing program. This program seems to have caused a drop in enrolment at Vancouver General Hospital (VGH), and “the Nursing Committee of the Board of Trustees discussed the possibility of creating a two-year programme at the VGH” in 1968.⁵³ This proposal would have removed the service portion of student labour in the hospital; as a result, students would be responsible for the cost of their education, a decision that created barriers for young women who could not afford a university education. This proposal was implemented and the two-year programs did create a drop in residential program enrolment, despite the cost to students.

St. Paul’s Hospital School of Nursing, Vancouver, British Columbia

St. Paul’s Hospital was named in honour of Bishop Paul Durieu, a member of the Catholic Oblates of Mary Immaculate in New Westminster, BC. Bishop Durieu saw the need for a hospital in the growing city of Vancouver. As a result of his request to the Sisters of Providence in Portland, Oregon, two members of that Catholic women’s order (founded in Montreal in 1843) purchased seven lots on the edge of Vancouver in 1892. A twenty-five-bed hospital opened in 1894.

Initially, students lived on the top floor of the hospital until a two-story building was constructed behind the hospital in 1908. It became known as the Nurses’ Home. St. Paul’s offered a three-year program, and instruction consisted of classes led by visiting medical staff or the Sisters of Providence, and then apprenticeship with senior nurses on

⁵² Nora Kelly, *Quest for a Profession: The History of the Vancouver General Hospital School of Nursing* (Vancouver: Evergreen Press, 1973), 155.

⁵³ *Ibid.*

the hospital wards. The three-year program was consistent throughout the life of the school. “In 1931 a new six-story Nurses’ Home with room for 166 occupants was opened at 1056 Comox St., and the name of the school was changed to St. Paul’s Hospital School of Nursing.”⁵⁴ In exchange for their work in the hospital, students lived together in purpose-built residences located on the top floor of St. Paul’s Hospital. Students were required to be female and to live in residence, and they were not permitted to marry during their training period. These restrictions remained in place until the late 1960s, when students were permitted to marry in the last year of their training.

Whether Catholic or non-Catholic, students were expected to provide character references from a pastor or priest or someone from their religious community. These references were an essential part of the application package. Although Catholic schools of nursing emphasized Catholic doctrine, students who were not Catholic, including Jewish students, were also admitted “by special permission.” The St. Paul’s school closed in 1974, having graduated 3,992 nurses.⁵⁵

The University of British Columbia School of Nursing (UBC)

The UBC School of Nursing was the first university school of nursing in Canada.⁵⁶ Locating nursing within a university setting was seen as one opportunity to open up higher education to women and give them access to the growing prestige of a

⁵⁴ “St. Paul’s Hospital (Vancouver, B.C.) School of Nursing,” authority record at the Memory BC website, <http://memorybc.ca/st-pauls-hospital-vancouver-b-c-school-of-nursing;isaar>.

⁵⁵ Ibid.

⁵⁶ The history presented here draws primarily on the excellent scholarship of Dr. Glennis Zilm and Ethel Warbinek in *Legacy: History of Nursing Education at the University of British Columbia 1919–1994* (Vancouver: UBC Press, 1994), 314. While other histories of the school have been written, including one by Nora Kelly (*Quest for a Profession: The History of the Vancouver General Hospital School of Nursing*), Zilm and Warbinek’s work is not only a history of the events that impacted the school, but also a critical social history of nursing education in Canada and in British Columbia. At each point in their history of the UBC school, Zilm and Warbinek tie together the social, political, and economic factors that influenced the development of nursing education, while at the same time critically summarizing the major accomplishments and challenges of the school and its leaders between 1919 and 1994. Commentary on the UBC School of Nursing provided in this chapter would not have been possible without their work.

university education. As Glennis Zilm and Ethel Warbinek explain, “Training schools for nurses were among the first higher level educational institutions in B.C.”⁵⁷ of any kind. The UBC program also furthered nursing leaders’ aim to distinguish nursing as a woman’s profession on a par with male-dominated professions such as law and medicine. At the same time, they viewed a university education as a means of distancing nursing from domestic service, from the perception that schools of nursing were unregulated, and from the image of nursing as a form of indentured labour.⁵⁸

The first five-year program leading to a baccalaureate in nursing was offered through the UBC Department of Nursing in connection with the Faculty of Science. The program included an initial year of university courses, two years in an approved hospital program, with a final year at UBC in a specialty of choice. Student practice took place at VGH under the direction of Ethel Johns.⁵⁹ When Johns arrived at UBC, “she had the foresight to see that a strong, science-based, liberal education for nurses belonged in the university system, paid for from educational budgets.”⁶⁰ Johns faced many obstacles in implementing her vision, including resistance to the idea that women should, or could benefit, from advanced education—particularly in such a profession as nursing, which was assumed to express women’s “natural” ability to care.⁶¹

Ethel Johns. Ethel Johns was Superintendent of Nurses at VGH between 1919 and 1925 and an important feminist influence in nursing in British Columbia. According to Zilm and Warbinek, Johns was a champion of nursing, women’s rights, and the professional image of nursing: “She emphasized the honour as well as the responsibility

⁵⁷ Zilm and Warbinek, *Legacy*, 5.

⁵⁸ *Ibid.*, 5–6.

⁵⁹ *Ibid.*, 24.

⁶⁰ *Ibid.*, 25.

⁶¹ *Ibid.*, 24–59.

that every nurse in the Hospital should feel in taking part in opening these new doors for nurses and women to achieve university-level entry for their education.”⁶² Another achievement under her stewardship was that “in B.C., the Graduate Nurses Association...established the first minimum standards for schools of nursing in 1924 [and] ... in 1926, the association’s right to set standards for the schools [of nursing in B.C.] was upheld by law.”⁶³

Evelyn Mallory. For most of the period under study, Evelyn Mallory (1941–1967) served as professor and director of the School of Nursing at UBC. Beginning in the 1952–53 academic year, Zilm and Warbinek explain, “Nursing education was moving into postsecondary institutions with budgets controlled by the provincial departments of education, rather than health, and, across Canada, hospital-based diploma schools were beginning to be phased out.”⁶⁴

Beth McCann. Beth McCann took over as director of the UBC School of Nursing from 1967 to 1971. Zilm and Warbinek comment that the McCann years at UBC included a number of important events in nursing education history. During this period many of the hospital schools of nursing were closing and the community college programs were expanding. Also, more men were entering the profession, with the first male nursing student graduating with his baccalaureate from UBC in 1973. This was a time when “UBC, like other universities across Canada, was male-dominated, and its administrative ranks even more so. The director of the School of Nursing frequently was the only female in senior academic meetings.”⁶⁵

⁶² Ibid., 45.

⁶³ Ibid., 68.

⁶⁴ Ibid., 143.

⁶⁵ Ibid., 179.

The Vancouver General Hospital School of Nursing (VGH)

The first graduation from VGH took place in 1929, and the last joint UBC/VGH graduation ceremony was in 1990. In the 1950s, the VGH diploma program consisted of blocks of classroom time, followed by blocks of hospital ward time. In 1958, a new program, called the “integrated system,” was introduced. The integrated system combined classroom time with clinical time on the wards. Public health teaching was added, which included four weeks with the “Outpatient Department at the Hospital, the Metropolitan Health Committee, the VD Control Clinic, and the VON. [In addition] there were to be four weeks of TB nursing and some experience in administration and assisting in clinical teaching.”⁶⁶ The VGH School of Nursing graduated its last diploma student in 1991. Over the ninety-nine years of its program, it had graduated 8,768 nursing students.⁶⁷

Nursing Education in Calgary

The history of Calgary schools of nursing presented here draws on the work of historian Pauline Paul.⁶⁸ Paul traces the history of the diploma schools of nursing in Alberta to the 1920s, when hospital-based programs operated independently and there was no common provincial standard for nursing schools. In 1921, the University of Alberta’s Committee on Small Hospitals began to supervise the diploma programs.⁶⁹ While the committee did have a mandate to monitor the quality of the schools and attempt to set standards, many small rural schools operated outside these standards. In the

⁶⁶ Ibid., 147–148.

⁶⁷ Zilm and Warbinek, *Legacy*.

⁶⁸ Pauline Paul, “Nursing Education Becomes Synonymous with Nursing Service: The Development of Training Schools,” in *Prepared to Care: Nurses and Nursing in Alberta*, ed. Janet C. Ross-Kerr (Edmonton: The University of Alberta Press, 1998): 129-148.

⁶⁹ Ibid., 134.

late 1940s, “a position of advisor to schools of nursing was established.”⁷⁰ Even then, hospitals continued to operate under their own standards and to obstruct efforts by the Alberta Association of Registered Nurses and the Committee on Nursing Education to enforce standards through training regulations. Paul explains that, as was also the case in British Columbia, it was essential for a school of nursing to be established in conjunction with a hospital in order to make it economically feasible. Paul concludes that, “It is unlikely that this situation was unique in western Canada or in North America, as the new schools were established based on the service that could be provided by women.”⁷¹

The Holy Cross School of Nursing, Calgary, Alberta

The Holy Cross Hospital School of Nursing was founded in 1891 by four members of the Order of the Sisters of Charity (or Grey Nuns). In 1966 a reconstruction of the hospital led to the demolition of the original building except the 1928 McNabb wing.⁷² In 1969, Holy Cross was sold to the provincial government, and two years later, control of the hospital was turned over to the Metro-Calgary and Rural and General Hospital District, which became the Calgary Regional Health Authority.

The Holy Cross School of Nursing, attached to the hospital, was established in 1907 under the direction of Sister M. Fafard. The school accepted students from all denominations, although they were required to be female and single and to remain as residents of the school throughout their three years of training. In 1970, the school, too, came under the jurisdiction of the Metro-Calgary and Rural and General Hospital District, along with the Holy Cross and Rockyview Hospitals. In the 1970s, changing

⁷⁰ Ibid.

⁷¹ Ibid., 135.

⁷² “Holy Cross Hospital, Calgary Alberta,” digital record at Community Heritage and Family History website, <http://cdm280501.cdmhost.com/cdm/singleitem/collection/p280501coll15/id/1402>.

attitudes about the apprenticeship model of nursing education, and changing mores surrounding women's social roles—specifically around the requirement to remain single while in nursing training—coincided with the decision to cease enrolment, with the last graduates receiving their diplomas in 1979. Over its history, the school had graduated 2,410 nurses.⁷³

The three-year curriculum at Holy Cross in the mid-1960s reflected the curriculum of other diploma programs in Alberta and British Columbia. Upon completion of this program, successful students could write the Conjoint Examinations. If they passed, they were then eligible for registration with the Alberta Association of Registered Nurses and, through that body, for association with the Canadian Nurses Association and the International Council of Nurses.⁷⁴

The Calgary General Hospital School of Nursing

Calgary General Hospital (CGH) was established in 1890, fifteen years before Alberta became a province. In 1953 a new CGH was built, increasing capacity from 320 beds to 626 beds. At the point of that expansion, there were not enough nurses to staff the main hospital. According to Sharon Richardson, “The crisis was largely the outcome of poor organization in the CGH’s nursing service division, and not simply the result of a perceived post-war shortage of graduate nurses.”⁷⁵ Conditions at the hospital reached a crisis point when “82 of the CGH’s 85 graduate nurses [threatened] to resign *en masse* by the last day of February 1952, ‘unless immediate steps are taken by the Board to

⁷³ “Holy Cross School of Nursing (Calgary, Alberta),” description of the Holy Cross School of Nursing fonds. In University of Calgary Library Special Collections, <http://www.ucalgary.ca/lib-old/SpecColl/holycros.htm>.⁷⁴ Ibid.

⁷⁴ Ibid.

⁷⁵ Sharon L. Richardson, “‘Stand Up and be Counted’: Nursing at the Calgary General Hospital after the Second World War,” *Canadian Bulletin of Medical History* 18, no. 2 (2001), 297, 306.

implement our recommendations’.”⁷⁶ Nursing Director Gertrude Hall undertook “the onerous task of dragging the CGH nursing division into the 20th century.”⁷⁷ She restructured the nursing training program to include intensive classroom instruction before students took on clinical practice. Hall instituted a rule that student nurses could not interrupt their assigned clinical rotation in response to the labour needs of the hospital. She also reduced the students’ time on the ward to eight hours, which included classroom instruction. Additional clinical experiences were arranged at the Alberta Mental Hospital at Ponoka and at a number of other specialty hospitals in the Calgary area. Hall worked with architects to design and build a new combined school of nursing and nurse’s residence, which opened in 1956.

The CGH diploma-nursing program was three years in duration, as was common at other schools. In 1959, Hall was the director who engaged in discussions with the University of Alberta about setting up an arrangement similar to the one between UBC and the VGH School of Nursing. This also would be a “sandwich” program, with two years at the University of Alberta (Calgary campus) and three clinical years at CGH. As in the UBC program, students took one year at university, followed by three clinical years and then one more year specializing at the university. One of the barriers was that CGH students did not all have their Grade 12, which made it difficult to integrate the two programs. After considerable discussion, the affiliation idea was dropped.

In 1960, budget restrictions meant Hall was called upon to reduce nursing staff. She refused and resigned. Margaret Street, associate director of nursing administration, also resigned. A number of other hospitals were built in Calgary in the wake of increased

⁷⁶ Ibid., 307.

⁷⁷ Ibid., 308.

population pressure, taking some of the prestige and focus of attention away from CGH. Enrolment at “the General” declined in the early 1970s, and in 1974 the CGH School of Nursing closed after graduating 2,940 nurses.⁷⁸

The Foothills Hospital School of Nursing

The Foothills Hospital School of Nursing in Calgary, Alberta, opened in 1965; the last students graduated in 1995. Bucking national trends, this was the last hospital-based residential school of nursing to open in Alberta. Students at the Foothills School could take first-year university courses and apply those courses to obtaining their baccalaureate degree at the newly established School of Nursing at the University of Calgary, following the completion of their three year diploma program. Before this time, students who desired a university degree in nursing had to travel to the University of Alberta in Edmonton. When the Foothills residential program opened, it was administered by an associated director of nursing education under the direction of the director of nursing at Foothills Hospital. This director reported to the hospital administration. Following a decision by the Ministry of Advanced Education and Career Development to close diploma schools of nursing, the Foothills Hospital made plans to close in July 1995. Responsibility for students in the diploma program was then transferred to Mount Royal and the University of Calgary. The Foothills Hospital was the last hospital-based school of nursing in Calgary to close its doors.⁷⁹

⁷⁸ Ibid.

⁷⁹ Description of Foothills Hospital School of Nursing fonds. at the University of Calgary Archives on the Archives Society of Alberta website, <http://asalive.archivesalberta.org:8080/access/asa/archaa/display/UOFC-1353>.

Summary

This brief history of nursing education in Alberta and British Columbia provides a social and historical context for a critical analysis of the experiences of women who graduated from hospital-based and university-based programs of nursing in Calgary and Vancouver between 1958 and 1977. This period saw significant changes in the role of nurses in health care. In the early post-war era, nursing education continued to emphasize bedside nursing skills, although “debates within the profession increasingly divided nurses into two groups: ‘technicians’ who remained at the bedside and ‘professionals’ who moved away from the bedside (and from body work) into positions of leadership, management, and education.”⁸⁰ As Toman has argued, by the 1970s, the use of technology, and the skill required to operate an increasingly complex array of technologies within hospital specialty areas, raised a question for nurse educators: “Were nurses technicians based on skills or were they professionals based on a distinct body of knowledge?” As divisions deepened between the two streams of nursing education that emphasized either care of the patient’s body (the diploma programs) or managing that care (the university programs), diploma nurses increasingly found their opportunities to move “upward” into management positions were limited. These divisions and limitations developed into the unionization/professionalization debates described in later chapters. Educational credentialing was at the centre of these debates.

⁸⁰ Ibid.

CHAPTER FOUR

Desiring Nursing: Hospital-Based Programs

From the time I was very young, I always wanted to be a nurse, and I guess there was a caregiver part of me that just wanted to do that. And I followed through and I always knew. I didn't ever go from side to side and change my idea. I wanted to be a nurse and I followed everything along the way, and that was what I did. And I was always happy that I did go into nursing, because it was who I was.¹

Karen, graduate of St. Paul's Hospital School of Nursing, 1961

The prevailing historiography of nursing education in the 1960s and 1970s suggests that young women entering nursing school did so due to a lack of other options and that nursing school in these decades represented a form of indentured servitude and acquiescence to the naturalness of women's subservient social status.² Analysis of interviews with women who entered nursing in this period presents a more complex and contradictory picture of nursing education and nursing in these decades.

In support of these claims I present three main arguments. First, while young women who entered nursing school faced strict forms of social and moral regulation, these were not unusual or different than the moral regulation of young women in the broader society. Rather, the rules and regulations under which these young women trained and worked were familiar to them, and reflected prevailing norms for working- and middle-class, white, Christian young women in the post-war period. In fact, despite the unusualness of young unmarried women living away from home to obtain an

¹ "Karen," interview with author, January 26, 2011.

² Alice J. Baumgart and Rondalyn Kirkwood, "Social Reform Versus Education Reform: University Nursing Education in Canada, 1919–1960," *Journal of Advanced Nursing* 15, no. 5 (1990): 510–516; Ina J. Bramadat and Karen I. Chalmers, "Nursing Education in Canada: Historical 'Progress'—Contemporary Issues," *Journal of Advanced Nursing* 14, no. 9 (1989): 719–726; Patricia D'Antonio, "Women, Nursing, and Baccalaureate Education in 20th Century America," *Journal of Nursing Scholarship* 36, no. 4 (2004): 379–384; Margaret J. Hegge, "The Lingering Presence of the Nightingale Legacy," *Nursing Science Quarterly* 24, no. 2 (2011): 152–162.

advanced education, the strictness of the student nursing residence assured parents that their daughters were being kept morally and sexually safe while also gaining skills that would lead to a professional designation, and to respectable and stable employment.³

Second, I argue that rather than being a choice for young women that was inferior to other options, the three-year nursing diploma program offered these young women of working-class families an acceptable, accessible, and affordable form of advanced education leading to a credential that was not otherwise easily available. Alternatives to nursing education, such as teaching or secretarial programs, were of much shorter duration, required money for tuition, textbooks, and lodgings, and led to much lower pay and social status than nursing.⁴ For example, according to Damien Brennan, single women dominated the lower ranks of the teaching profession, regardless of their level of education.⁵ In nursing, however, women occupied all levels of their professional hierarchy. In addition, for daughters of middle-class families, nursing was one of the few university practice-based programs open to women in the 1960s and 1970s.

Finally, I argue that at a time when marriage and motherhood dominated the lives of most adult women, the choice to become a professional nurse did not necessarily preclude or contradict the decision to marry and become a mother. Instead, in these

³ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing 1900–1990* (Toronto: Oxford University Press, 1996); Baumgart and Kirkwood, “Social Reform Versus Education Reform.”

⁴ Sheila L. Cavanagh, “Female-Teacher Gender and Sexuality in Twentieth-Century Ontario, Canada,” *History of Education Quarterly* 45, no. 2 (Summer 2005): 247–273; Elizabeth Edwards, *Women in Teacher Training Colleges, 1900–1960: A Culture of Femininity* (London: Routledge, 2001); Ross Finnie, Arthur Sweetman, and Eric Lascelles, *Who Goes? The Direct and Indirect Effects of Family Background on Access to Post-Secondary Education*, Research Paper Series, no. 237 (Ottawa: Statistics Canada, Analytical Studies Branch, 2005).

⁵ Damien Brennan, “Commentary. The Social Construction of ‘Woman’s Work’: Nursing Labour and Status,” *Journal of Nursing Management* 13, no. 4 (July 2005): 282–5; see also: Paul Axelrod, “Historical Writing and Canadian Education from the 1970s to the 1990s,” *History of Education Quarterly* 36, no. 1 (Spring, 1996): 19–38; Alastair Glegg, “Right-Minded Teachers: The Influence of the Socio-Political Context on the Preparation of Teachers in British Columbia, 1872–2002,” *Journal of Educational Administration and History* 37, no. 1 (April 2005): 19–37.

decades, nursing offered one of the few acceptable and respectable employment opportunities for married women with children. The gendered nature of nursing and the demand for nurses under the new publicly funded health-care system meant that graduating nurses, whether married or single, were presented with a number of unusual opportunities, including immediate employment, future career advancement, and professional status.

Support for these three major claims emerges through conversations with women who entered nursing school in the 1960s and early 1970s and graduated three, four, and five years later as registered nurses. Power exercised through discourses of gender, race, class, culture, and religion as well as the governing discourses of the nursing school selection and admission processes shaped the experiences of young women in nursing school, but at the same time, these young women were not passive agents of conformity. Only one woman withdrew due to pregnancy, and she returned to complete her diploma within three years of withdrawing. None withdrew due to marriage, ill health, or failure to complete the program, although several married in secret while still in their program, against the schools' policy. Thirty-five of thirty-seven married, and thirty-three of thirty-seven had children. All women worked full- or part-time in nursing for various amounts of time following graduation, marriage, and motherhood. Only three did not continue working in nursing following marriage. Twenty-two of thirty-seven women interviewed obtained an advanced degree or certificate in nursing beyond their basic diploma or degree

Acts of resistance, and critical questioning of the rules and regulations under which they lived and worked, highlight ways in which this generation of women and

nurses acted as agents of social change and self-emancipation to maximize the short- and long-term benefits of their nursing education.

Choosing Nursing

Although there were a number of shorter college-based programs in Ontario, and later in Alberta and British Columbia, for the majority of students, hospital-based and classroom instruction included time spent living in student nursing residences attached to hospitals and were at least three years in duration. Students at the University of British Columbia School of Nursing (UBC SON) spent one year enrolled in university-level courses, two years in a hospital-based training program and then an additional one year back at the university, where they focused on public health, administration, or nursing education.⁶ Competitive entry to both the diploma and degree programs meant that only students with higher than average grades were admitted, yet there were waiting lists to gain admission to nursing school. Given this strict code of conduct and competitive admission process, and the strictness and length of both programs, what made a career in nursing so desirable?

Desiring/Desirability of Nursing

Young women desired nursing for a number of practical, moral, or fanciful reasons. In fact, however, there were few other career alternatives available that had the status afforded by nursing. As Veronica Strong-Boag explains, women's employment options were limited: "Married women were found in female occupational ghettos, characterized by limited wages and restricted opportunities. Very few were privileged

⁶ Ethel Warbinek and Glennis Zilm, *Legacy: History of Nursing Education at the University of British Columbia, 1919-1994* (Vancouver: University of British Columbia School of Nursing, 1994).

professionals.”⁷ Nursing was unique in offering one of the few educational preparations that would enable a woman to qualify for a professional credential. Gail, a graduate of VGH in 1971, recalled:

We weren’t exposed to any women professionals growing up, except for teachers and most of our teachers were men. It was a very narrow, protected environment we grew up in, suburban post-war white North American Vancouver.⁸

When I asked Penny, a graduate of the Holy Cross in 1961, why she chose nursing, she replied:

You could either be a nurse, a teacher, or take secretary’s courses... At that time, so, I mean, there weren’t very many other opportunities for women and I know that my one friend went up to University of Alberta, because there weren’t any universities except up there, and she went and took Pharmacy. And that was really unheard of. She was one of the only females in her class.⁹

Even as opportunities opened up for women in universities, retail, public service, and business, they were generally inaccessible to the daughters of working-class families. Many working-class families did not have money for children’s post-secondary education, and particularly for a daughter’s education.¹⁰ Cathy, a graduate of the Foothills Hospital School of Nursing in 1971, recalled:

The messages that came out of my family, and it would be my parents in particular, was that I, as a woman, would get married. And so getting married and raising children was a preferred career, and embarking on a career outside of that was going to be short-lived. So even the sense of investing in that [education] instilled some doubt.¹¹

⁷ Veronica Strong-Boag, “Canada’s Wage-Earning Wives and the Construction of the Middle Class, 1945–60,” *Journal of Canadian Studies/Revue d’Études Canadiennes* 29, no. 3 (1994): 13.

⁸ “Gail,” interview with author, January 21, 2011.

⁹ “Penny,” interview with author, January 31, 2011.

¹⁰ Ross Finnie, Arthur Sweetman, and Eric Lascelles, *Who Goes? The Direct and Indirect Effects of Family Background on Access to Post-Secondary Education* Research Paper Series, no. 237 (Ottawa: Statistics Canada, Analytical Studies Branch, 2005).

¹¹ “Cathy,” interview with author, January 14, 2011.

Nursing education within the diploma programs was available at a very low cost; thus, nursing was an affordable and accessible option for the education of daughters of working-class families. Shelley, graduate of the Calgary General Hospital School of Nursing in 1966, remembered:

Back in the '60s, times were hard and nursing seemed to be an avenue that was not a very costly education at the time. In fact, it was very minimal what we had to pay for. They [parents] could see it was a good career and developed a lot of qualities in us that they felt were desirable, like honesty and maybe some leadership roles, learning how to pass and finish and complete a task, and discipline.¹²

Similarly, as Mona, a graduate of the Calgary General in 1967, recalled:

In those days, of course, women didn't have great choices about what you could do, even in school. My dad was a mechanic. I loved mechanics, but we couldn't take mechanics as an option. We could only take sewing and cooking and traditional stuff. And then so going into university, of course, there was, there were two factors. Number one, not great choices for women, again, in university, and the second thing was, my family didn't have a lot of money and it only cost \$100 to get into nursing, compared to going to university, which was going to be much more expensive.¹³

For middle-class families, nursing was one of the only professional schools at the university level that facilitated women's career advancement. Kelly, who graduated from the UBC School of Nursing in 1967, remembered:

When I graduated from university, people were banging on my door to work with them. There was a real shortage of nurses then. I could have worked anywhere. They hired me on the spot in a classroom at UBC; nobody was without a job. I found myself a head nurse on a psych ward within the fall of '69 two years after graduation. I had two years of public health nursing background, no experience of psych except for Riverview Mental Hospital. Then at the tender age of 26 or so, with very limited experience, I became the assistant director of nurses at a regional hospital.¹⁴

¹² "Shelley," interview with author, January 10, 2011.

¹³ "Mona," interview with author, January 18, 2011.

¹⁴ "Kelly," interview with author, January 28, 2011.

For working-class families, guaranteed employment ensured economic stability, and for middle-class families, an advanced education for a daughter was a respectable segue into the increasing desirability of the two-income family.

Christian Values

The dominance of Christian values in nursing school was also an attraction for the families of working- and middle-class young women. Christianity was a dominant governing discourse in post-war Canada.¹⁵ Nancy Christie explains that in the immediate post-war era, as in the pre-war era, the culture of Christianity dictated behavioural norms within the family, and these norms reflected governing discourses within the broader society. Christie argues that “a ‘patriarchal’ set of hierarchical social and political relations ... continued to be ideologically dominant.”¹⁶

Holding Christian values was an influencing factor in whether a young woman would be accepted into nursing school. The relationship of nursing and Christian religious values was a recurring theme in the interviews, and religious orientation was a requisite disclosure on all application forms that were reviewed for this study. Pauline, a graduate of the Calgary General in 1965, remembered:

We were pretty similar, pretty similar, just in terms of religious orientation and I guess culture. There was one person in my class who was a different nationality, although she was Canadian. But everybody else was white.¹⁷

Here, Pauline makes an association between being similar, being white, and being Christian. Whiteness and Christianity were closely related in identifying suitable young

¹⁵ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50* (Vancouver: UBC Press, 1998).

¹⁶ Nancy Christie, *Households of Faith: Family, Gender and Community in Canada* (Montreal: McGill-Queen's University Press, 2001), 377.

¹⁷ “Pauline,” interview with author, January 17, 2011.

women for nursing. It appeared that if you were white, you were also Christian, as Mona, a graduate of the Calgary General in 1967, remembered:

M: We had to go to chapel six days a week, Monday to Saturday. On Sunday we didn't because there was church service in the hospital somewhere, we could go to that. And when you went to chapel, you had to put your name on a slip of paper and put it in. Our supervisor was standing there and you had to slip it in. If you didn't make it to chapel, you were grounded and you had to be in by 9 o'clock, that sort of stuff.

MS: Well, what if you weren't of that faith?

M: It was a non-denominational.

MS: But if you weren't Christian?

M: I guess that was never a question.

MS: So it didn't stand out at the time that there might have been anybody, say, from a different belief system or anything?

M: No, and I think we even had a Jewish gal, but it just wasn't a big issue. It was a ten-minute service sort of thing. Nobody—they knew this before they came into nursing. We were all told we would have to go to chapel and I guess if you didn't like it, you didn't go.

MS: So there were consequences, then, for that?

M: Oh, definitely. There were lots of consequences for different things.¹⁸

Within the student nursing residence, symbols of a Christian life were ubiquitous.

As Tina Block explains, in mid-twentieth-century Canada, Christianity was a pervasive and visible presence in the everyday routines of most Canadian's lives.¹⁹ According to Lynne Marks, however, historians of the working-class have largely ignored the influence of Christianity.²⁰ The unacknowledged pervasiveness of Christianity in the lives of the dominant class was revealed when I asked one interviewee if the “non-

¹⁸ “Mona,” interview with author, January 18, 2011.

¹⁹ Tina Block, “Families That Pray Together,” *BC Studies* 145 (Spring 2005): 31–54 [electronic version], 2.

²⁰ Lynne Marks, “Challenging Binaries: Working-Class Women and Lived Religion in English Canada and the United States,” *Labor: Studies in Working-Class History of the Americas* 6, no. 1 (2009): 107-25.

denominational” schools followed similar religious observances to the overtly Catholic schools. She replied, “No.” When I asked her if they attended chapel and said prayers, she replied, “Of course!”²¹

The association of nursing with Christian traditions also ensured the social acceptability of a daughter’s choice to seek paid employment, an option that did not necessarily conform to standards of working- or middle-class Christian values. As Peggy, a graduate of the Holy Cross in 1969, explains, her parents allowed her to enter a Catholic nursing school because it matched their Christian family values, specifically their assumptions about women, God, and caring:

The Holy Cross was run by the Gray Nuns from Montreal ... their philosophy was that nursing wasn’t just a career, it was a vocation. It was a calling from God. You were called to this profession because you wanted to serve and look after people during illness times.²²

Peggy’s parents believed that Christian values were encouraged and enforced in schools of nursing, and that this was desirable. This belief was confirmed by the fact that every nursing residence had a chapel, as did every hospital and university. Karen, a graduate of St. Paul’s in 1961, remembers that the nuns controlled them, but it was a familiar form of control, and symbols of that control were also familiar. Karen explained:

It was automatically St. Paul’s because I was Catholic, and at that time your parents would automatically insist that you go there. But then I also thought that I wanted to as well because it was known for not being as large and that was a factor and also, I guess, the fact that the nuns were running it, I felt like it was home.²³

Colin Gordon explains that power is exercised through acts and rituals that, “shape and control the behaviour of individuals situated within a range of social and

²¹ “Mona,” interview with author, January 18, 2011.

²² “Peggy,” interview with author, January 7, 2011.

²³ “Karen,” interview with author, January 26, 2011.

economic institutions such as the school, the factory and the prison.”²⁴ In schools of nursing such as Catholic ones—St. Paul’s in Vancouver and the Holy Cross in Calgary—the nuns exercised a particularly obvious degree of regulation that shaped and controlled the behaviour of their pupils. Penny, who graduated from Holy Cross School of Nursing in 1961, remembered:

When we were on duty during the day we had to go for meals ... and they [the nuns] were very strict. You had to have your uniform clean and polished. I mean, they did that for you, but if you had a wrinkle or a run in your stockings, you had to file out past Sister Sergeant on the way out to the unit, and if she saw something wrong with your uniform, your pin wasn’t right or your cap was crooked, or whatever, she’d tap you and you’d have to stand beside while everybody paraded by you, and then she’d say to you, “Miss Stark, can you not afford stockings?”²⁵

Likewise, Audrey remembered that:

Number one, we were expected to excel at our courses. And forced study time made us study. We were supposed to be well rested when we went on the units, and having to be in by 10:30 didn’t guarantee you went to bed by 10:30, but at least you were in residence at 10:30. I think it was just discipline.

MS: So that, as you say, there were some real expectations around being rested and able to put in the day and also to learn at the same time. So, it sounds like, they were thinking that this would give you those opportunities to study and be rested.

A: Yes.....a kind of benevolent dictatorship.²⁶

Dina, a graduate of the Calgary General in 1965, remembered that the rules of nursing school were familiar to her. Dina explained that:

In addition to being very strong, my mother was a strong disciplinarian. And so consequently there were lots of rules. For instance, when I was a teenager I could only go out one night of the weekend. And that would also be true in the summer time. And all of a sudden, when I’m in nursing,

²⁴ Colin Gordon, “Governmental Rationality: An Introduction” in *The Foucault Effect: Studies in Governmentality* ed. Graham Burchell, Colin Gordon, Peter Miller (Chicago: University of Chicago Press, 1991), 3-4.

²⁵ “Penny,” interview with author, January 31, 2011.

²⁶ “Audrey,” interview with author, February 8, 2011.

my gosh, it wasn't limited to weekends. You could make ... so even though some of the rules were constricting in terms of, you know, you only got two nights a month or something like that, you could work around the format. We would have to do things like, we'd all have to go to Chapel—we had three chapels to go to. And we had to sign in, so you had to put your piece of paper with your name on it to make sure that you went to chapel. And, you know, I was brought up Presbyterian and I had no problem with that, but it just seemed sometimes the rules were a little silly.²⁷

Gordon explains that there is also resistance to control. Thus, Pauline, a graduate of the Holy Cross, recalls how students “worked around” the rules of religious observation:

We had compulsory chapel in the morning, unless you had a friend who was willing to drop your name in the container [to prove you had attended], so it wasn't optional.²⁸

Image of Nursing

Nursing was respectable, but it could also symbolize becoming a modern woman. The uniform of the student nurse included many individual pieces that needed constant attention in order to conform to the required, and desirable, image of the aspiring professional. The nursing uniform could also be a display of fashion. The shoes, the cap, the crisp white bib and apron that adorned women in nursing could act as fanciful images of adult maturity. Reflecting on her childhood image of nursing, Peggy recalled:

Given that I'm Italian, I was brought up in a Roman Catholic faith. On Sundays, in grade 7 up to grade 12, we used to go to the Calgary General Hospital and bring patients to mass ... And I think, well, and that's where I started to see all these wonderful nurses. Walking in the hallways with their hats and white uniforms, and I'd think, 'Oh, wow, that's really what I want to be.' I liked the fact that their uniforms looked quite wonderful. And that they would be walking around and helping all these sick people. I was attracted by that.²⁹

²⁷ “Dina,” interview with author, January 18, 2011.

²⁸ “Pauline,” interview with author, January 17, 2011.

²⁹ “Peggy,” interview with author, January 7, 2011.

Nurses' uniforms were feminine, but not provocative, and conveyed an air of competence, authority, and maturity. Cathy, a graduate of the Foothills Hospital School of Nursing in 1971, describes a cousin who was a nurse:

She was an older cousin who I really admired ... She appeared very happy, exciting, yeah, it just really cemented that notion that being a Registered Nurse could be a lot of fun or a profession worth considering. I knew that there were lots of options [in nursing] and when I read the program it looked like it would prepare me. I could be an administrator, I could be a teacher, I could be a public health nurse, or I could work in a hospital. So I thought, 'oooooh! That's a good full range!' She was dressed in her uniform and had a cape and I remember her hat and that had a profound impact on me, actually ... She looked very confident and there was something, I guess, about her being a nurse and certainly that image was very stylish....³⁰

Nursing uniforms had many functions, according to Christina Bates, only one of which was fashion.³¹ Nursing uniforms also reflected the religious and military heritage of nursing, and many uniforms in the first half of the twentieth century conveyed the image of the virgin, veiled, virtuous, and asexually cloaked nurse, safe from the prying eyes of men.³² As Bates explains, uniforms are clothing, and thus “the category of material culture that arguably has the greatest potential for exploring personal and social identify and values. Whether by choice or convention, what we wear is intimately connected with who we are. Dress is both personal and social, private and public, modest and daring, barrier and bait.”³³ Thus, the image of the nurse conveyed a set of complex social messages. On the one hand, the uniform needed to attract young women who were fashion conscious. On the other hand, it needed to give the public confidence in the professionalism and asexuality of the nurse as someone able to care dispassionately for

³⁰ “Cathy,” interview with author, January 14, 2011.

³¹ Christina Bates, “Looking Closely: Material and Visual Approaches to the Nurse’s Uniform,” *Nursing History Review* 18 (2010): 167-88.

³² *Ibid.*

³³ *Ibid.* 172.

both men and women in intimate situations. The values of religious and military traditions reflected in the construction of the uniform also served to assure parents that modesty and discipline were enforced if not embraced by those wearing that uniform.

For students, the nurse's uniform was required and monitored for its cleanliness and conformity, but it also symbolized belonging to a group of young women with a similar purpose and identity. Nursing uniforms were symbols of a shared identity and shared vision of the profession. The nurse's cap, for example, signified membership in a community of women who had spent three, four, and five years living together, working together, and sharing many common experiences. Each school of nursing had a distinct uniform, cap, pin, and cape, and these were often worn after graduation as well. There was pride in wearing your alma mater's uniform as a sign of respect for the membership, memories, and friendships it represented. As Val, a graduate from UBC in 1967, expresses, being recognized by others by your cap was part of an important social memory:

When I finally landed up in Mississauga in 1974 and it was my first day at the Mississauga Hospital there with the students, this voice shouts down the hall and says—we were still wearing caps—and this voice shouts down the hall and says, 'Hi UBC'! And I looked around and there was this graduate from Vancouver General, she'd recognized the cap. You know, that was in Ontario where you didn't see many people from the west that far away. That was really neat. But there was certainly something that we had then that people don't have now. We could recognize each other by caps.³⁴

Voices of Dissent

Not all families welcomed their daughter's decision to enter nursing, despite its affiliation with Christianity, and despite guarantees of employment, career advancement, or the suitability of nursing as women's employment. As Herbert Cross and Randall

³⁴ "Val," interview with author, January 19, 2011.

Kleinhesselink explain, prolonging adolescence by enrolling in post-secondary education conflicted with the usual trajectory of high-school completion, work, marriage, and parenthood.³⁵ Peggy's parents, devout Catholics, preferred that she follow this trajectory; a career in nursing, with its requirement to live away from parental supervision for three years, exposure to the very public forum of the hospital, and interaction with people outside the family circle, was threatening. Peggy describes her parents' fears:

I think at that time it was very difficult for my family. Girls from my background traditionally got married after high school and started a family. There were only two of us within at least 500 girls of similar age [in her community] who went into nursing. Everybody else, in 1966, kept with the traditional belief that you just didn't leave home and go and live in a residence. I think it was hard for my parents to accept that.³⁶

While Peggy may have felt confident to leave home and start a professional career, traditions that reinforced the role of the stay-at-home mother and the breadwinner father were still strong in this era. Historian Bryan Palmer explains that many Canadians were unsure about what would happen if men and women "changed" roles, and were in fact more *proponents* than *opponents* of existing gender roles.³⁷ While barriers to women's advanced education and career aspirations may have been crumbling on some fronts, families such as Peggy's may have preferred what they felt was a more predictable and secure future for their daughter.

Like Peggy, Cathy, a graduate of the Foothills Hospital in Calgary in 1971, recalls that her parents discouraged her efforts to go into nursing, because of the cost, and also because they did not expect her to remain in paid employment. In effect, some parents at

³⁵ Herbert J. Cross and Randall R. Kleinhesselink, "The Impact of the 1960s on Adolescence," *Journal of Early Adolescence* 5, no. 4 (1985): 517–31.

³⁶ "Peggy," interview with author, January 7, 2011.

³⁷ Bryan D. Palmer, *Canada's 1960s: The Ironies of Identity in a Rebellious Era* (Toronto: University of Toronto Press, 2009), 79.

the time viewed advanced education as a waste of time and money for daughters. Cathy explained:

At that point in time, I think I was very much aware that the assumption for my brother was different. The willingness to invest in his career seemed stronger than in my career, because I would be hitting the road of marriage and children. So I was aware of that difference and feeling some of the unfairness. But I'd seen that unfairness already, or what I positioned as unfairness, in relation to my mom and my dad too, and my mom's role, which was very much in the home and the cooking and the cleaning and the raising of children, a very traditional role.³⁸

Even middle-class parents did not necessarily encourage a daughter's plans for a career outside the home and family. In this period of shifting gender roles, the independence and self-determination implied by a career outside marriage and motherhood may not have been seen as desirable qualities to encourage; in fact, some may see them as a threat to the family/social order. Dora, a graduate of UBC in 1977, came from a rural town in British Columbia. Her parents were successful ranchers. Despite their higher income, they did not see advanced education as an advantage for their daughter. Dora recalled:

My mom was actually quite upset that I was going to leave and go to university. She did not want me to do that ... she never actually said that she was against women going to university but my older brother and sister never went on to higher education and she probably didn't think it was necessary. She probably didn't think I needed to go to university. That getting a nice solid grounding in a nice safe school of nursing in Victoria was just all I needed. Mom herself never finished high school. She probably thought the St. Joseph's [School of Nursing] was good enough as a female. My sister got a clerical job working at one of the lumber mills near town, and then you would be settled. And if I got a job as a nurse, then I would have a wage. I don't know if it was ever so much that she thought that I would get married and have a husband to look after me, but I think she thought that that would be an adequate job so that I could look after myself. That's all I needed.³⁹

³⁸ "Cathy," interview with author, January 14, 2011.

³⁹ "Dora," interview with author, January 19, 2011.

Social change, for many Canadians, was a slow process. Doug Owram claims that the counterculture revolution of the 1960s was not the revolution we have come to imagine through the popular media, but instead was actually dilute, diffuse, and of dubious significance for the majority of young people.⁴⁰ Rebellious women were often portrayed as morally suspect or degraded, coming from “bad” homes, he claims. Women who were ambitious were portrayed as leading a lonely spinster’s life.⁴¹ Owram makes the observation that, “thousands of middle-class teenagers might vicariously thrill to Brando or Dean, but few of the males dared wear a leather jacket.”⁴² This was because “the imagery of jeans and leather was associated with just the sort of poor broken family environments that the whole middle-class suburban lifestyle was constructed to avoid.”⁴³

The spirit of tentative rebellion, however, emerged in Dora’s reflection on her refusal to remain at her parents’ home following high-school graduation and her decision, instead, to enrol at the UBC School of Nursing. Dora did not see herself as rebellious—rather, her choice to attend university and her choice to become a nurse was a sign that she was mature enough to make an independent decision. As Dora explains, there were signs of change in the early 1970s in small-town British Columbia:

I think that my friends and I, we probably considered ourselves a little bit above many of the other girls that we graduated with because we weren’t, I mean, we had boyfriends and things like that, but it wasn’t, that wasn’t the—there were many girls who were very happy to stay in [small town on Vancouver Island] and get married and have children. That would have been the majority of our graduating class in high school. And so, the small little handful of us—we did see ourselves, I mean, at the time we didn’t necessarily—well, maybe we did. I would have to say that we probably

⁴⁰ Doug Owram, *Born at the Right Time A History of the Baby-Boom Generation* (Toronto: University of Toronto Press, 1996).

⁴¹ Valerie Joyce Korinek, *Roughing it in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties* (Toronto: University of Toronto Press, 2000); Joan Sangster, *Regulating Girls and Women: Sexuality, Family, and the Law in Ontario, 1920–1960* (Don Mills, Ont: Oxford University Press, 2001).

⁴² Owram, *Born at the Right Time*, 146.

⁴³ Owram, *Born at the Right Time*, 146.

felt a little bit above them because we did well in school and we sort of, we would consider it of value to not be out looking for a husband ... I don't really consider myself, I don't know that I'm really, what do we say? Worldly or questioning ... I tend to be a person who's a bit complacent. And tend to accept, be accepting, of how things are. And my coping mechanism may, probably, a little passive aggressive. My whole philosophy in staying, in being able to stay within the acute care setting, is that I like to fly under the radar. Because I find it's very difficult to bring in any change, and usually it's just troublesome when you so ... in nursing school, I was probably quite accepting of what went on. I was not tending—I would just play by the rules, always in class on time, always hand my assignments in on time. Whatever happened, happened, and I didn't tend to try to rock the boat or institute change.⁴⁴

Marriage, Career, and Employment

Dora may have rocked the boat when she left her family home to become a nurse at UBC, but she did not rock the boat when she married and had two children after she completed her degree. Her decision to attend UBC and work in nursing did not preclude marriage and motherhood. In fact, for some young women, a career in nursing was *preparation* for marriage and motherhood. A promotional brochure prepared by the director of nurse recruitment in Calgary in the mid-1960s, aimed at high-school girls and their parents, promised that “those who marry will benefit from their course in nursing. Of all the professions open to women, nursing ranks with the highest in social standing. Nurses are proud to be nurses and others are proud to know them.”⁴⁵ Rona, a graduate of the Royal Columbian Hospital in 1965, assured me that nursing was a good job and worked well with her mothering role:

Nursing [training] put me in good stead. It gave me lots of skills with my own children. I was never nervous about my babies or ... I go into homes all the time now with young couples and they'd had no preparation, they haven't babysat, young girls today didn't even play with baby dolls and

⁴⁴ “Dora,” interview with author, January 19, 2011.

⁴⁵ “Information for Prospective Student Nurses: A Career in Professional Nursing, 1965,” brochure of the Director of Nurse Recruitment, 1953–1970, Calgary General Hospital School of Nursing fonds., M-2456-345, Glenbow Museum Archives, Calgary.

change their diapers. They played with Barbie and changed her bra. And I played with dolls and I had babysat and then I had my nurse's training. I think it certainly was good preparation.⁴⁶

Mary, a graduate of St. Paul's in 1967, confirms that, indeed, nursing did prepare her for this important role:

My being a mother, again, was an unexpected happening in my life but it felt totally natural and I was really good at it. So it never conflicted with nursing. I don't know that nursing had any impact on—well, I think, maybe it did because I was confident about having a baby, a kid, I guess because of my “Peds” [pediatric] background [in nursing].⁴⁷

Not all women wanted to marry, although the majority eventually did. Vera, a graduate of UBC in 1962, recalls the ambiguity of this period in her life:

Well, I certainly knew I wanted to marry, I just didn't just want to marry to marry. I guess I wanted to marry—I don't know. When I was working in nursing I just kept working and I did interesting things and I just kept at it. A lot of my friends were single. Because I didn't get married until I was, until 1970, I had had eight years of moving ahead. So there were things I wanted to do in nursing. I did want to get married and I certainly did want to have children at some point.⁴⁸

Choosing nursing offered both short—pre-marriage—and longer-term—working motherhood—options. The idea that women could, or should, obtain employment skills and seek personal financial stability, and even a career, increasingly became a consideration and a possibility for working- and middle-class women.⁴⁹ Nursing offered these opportunities. Changes in trends and customs related to marriage, divorce, and birth control, for example, meant that employment skills might be a valuable asset for a woman, even if she was married and became a mother. Gail, a graduate of VGH in 1972,

⁴⁶ “Rona,” interview with author, January 25, 2011.

⁴⁷ “Mary,” interview with author, January 12, 2011.

⁴⁸ “Vera,” interview with author, January 31, 2011.

⁴⁹ Joy Parr, *Domestic Goods: The Material, the Moral, and the Economic in the Postwar Years* (Toronto: University of Toronto Press, 1999).

remembered that the potential for financial stability had been a necessity for her mother and that this influenced her decision to enter nursing:

My Mom thought that nursing was something to fall back on, because it was still the mindset that women were going to get married, have children, and it was just a bonus if you had an employable skill. It was there if you needed it, like if something went wrong in your marriage. Actually my aunt, who worked with my mother probably during the war years at Vancouver General—and my uncle died in his forties and she came back to Vancouver with three kids. She went back to work nursing to raise those three kids and so that kind of held true for her, but most of my mother's contemporaries would have been married and then not worked once they had children.⁵⁰

Financial stability was an attraction for some families who had been through difficult times during the war and after. Corrine's experience as a child of a single mother, and her mother's experience as a single parent in the 1950s, had an impact on her desire to become a nurse. Corrine's mother was concerned about her daughter's future and believed that nursing could act as "insurance" against possible financial uncertainty.

Corrine recalls how she understood her mother's suggestion to become a nurse:

My mother always drilled into me that you had to have some sort of education and career because my father died when I was nine and she was alone and she had to bring up two girls on her own. And she didn't have a lot of education. She definitely felt that having some type of education to fall back on, so that if you had to become independent, you had something there. So, again, that was another reason that I went on ... nursing was the least [amount of] time that I could get some type of education and a career ... although at the time you didn't really think of it as a career, you just really thought of it as a means of employment that if you were left on your own for ... some reason or another, you had something to fall back on. Probably at that time I wasn't thinking that I would nurse if I was married and had a family, it was more something that I would end up falling back on if I had to. I was too young to make a total decision.⁵¹

For Audrey, a diploma graduate of Holy Cross in 1964, being a nurse presented opportunities for employment, but also represented the traditions of service, caring, and

⁵⁰ "Gail," interview with author, January 21, 2011.

⁵¹ "Corrine," interview with author, January 7, 2011.

femininity that nursing stood for. Not only was nursing a virtuous career, but it was also employment that could augment the breadwinner's wage if the family wanted, or needed, more income:

My mom, in particular, now she was a nurse at the time when, when she married, she had to quit nursing. But she could see that nursing was a good profession for any girl because it gave so many opportunities. And of course by the time I graduated you could be married and nursing. So she just thought that there was always employment available. But I think she realized that I probably should be a nurse because of my personality.⁵²

For other women, nursing offered an opportunity for participation in the new “consumer” society.⁵³ Valerie Korinek, describing a new editorial approach in the popular women's magazine *Chatelaine*, explains that an increasing number of the magazine's middle-class readership in the 1960s, were working outside the home, and the image of the working married mother was changing. A series titled *Working Wives Are Here To Stay*, declared: “They're labelled luxury-mad materialists. They're blamed for delinquency and divorce. They're accused of throwing men onto breadlines. But the fact is Canada's 700,000 working wives are merely unrecognized pioneers in a social revolution.”⁵⁴ A career in nursing offered women a chance to become independent consumers and to be included in this new “social revolution” of waged married women. The status and upward mobility conferred by a university degree in nursing made participation in the new consumer society more possible.

Nurses with university degrees were rising into higher-paid management positions and accruing greater social status. As Dora, the young woman from a rural town on Vancouver Island who defied her parents and went away to UBC, explains, advancement

⁵² “Audrey,” interview with author, February 8, 2011.

⁵³ Parr, *Domestic Goods*.

⁵⁴ Korinek, *Roughing it in the Suburbs*, 326.

in nursing was possible because of her degree, which had quickly landed her an administrative position:

I think, because at that time, in order to get anywhere within the hospital setting—like, any advancement—it was beginning that you had to have your degree. So if you wanted to be the educator or the clinician or get the job in medical job in outpatients, the nice Monday to Friday job, to get the ticket out of shift work was a degree. So those nurses [who had a diploma in nursing] who felt that they—and rightly, they did know more than me, no question about that—but in order for them to get out of shift work, really the doors were closing on them for advancement. And being replaced by people like me who, in their perspective, knew nothing, and yet we were the ones who had the opportunity ... I was asked to sit on committees. And I don't know whether they turned them down, but I did do those kinds of things. I can remember sitting on a variety of different hospital committees, looking at various aspects of health care and things like that. So it was just seen as the perception was, how on earth would a university nurse be offered advancements when she knows nothing?⁵⁵

Selective Admission

Young women who desired an education in nursing, for whatever reasons, soon learned that admission to nursing school was competitive at both the university and diploma level. Gender, age, religion, and race influenced the student's chances of being accepted. With very few exceptions, students were between the ages of 17 and 30 years old, single, white, Christian, and female.⁵⁶ They were required to have a strong academic standing, personal references, and a record of good physical health. In 1968, there were a total of 217 applicants for student positions at the Calgary General; of these, only 106 were accepted.⁵⁷

Academic requirements for admission to three-year diploma programs in the mid-1960s varied across the country, ranging from British Columbia and Ontario, which

⁵⁵ "Dora," interview with author, January 19, 2011.

⁵⁶ McPherson, *Beside Matters*.

⁵⁷ "Statistics Regarding Applications to the School of Nursing, Calgary General Hospital, 1968," *Year-End Report by School of Nursing*, Calgary General Hospital School of Nursing fonds., M-2456-349, Glenbow Museum Archives.

required high-school graduation with university entrance or its equivalent, to Alberta, which required a certain number of high-school credits and a “B” standing or higher.⁵⁸ Preference was given to students with the best academic average, and for students with senior matriculation (Grade 13). At Holy Cross, following academic standing, the next criterion in the recruitment brochure was “Character and Personality.”⁵⁹ The school was looking for “good moral character motivated by the spirit of service. A liking for people and an ability to work with others, good judgment, kindness, sympathy, poise and resourcefulness.”⁶⁰

Each written application was accompanied by a letter from the applicant that stated her reasons for entering nursing, a statement by her physician that verified sound health, including an “absence of physical defects,”⁶¹ and three written character references, which were required to include, “one from a clergyman, one from the school principal or instructor and one from a responsible person who has known the applicant for some time and can testify to her good moral character and qualification for the nursing profession.”⁶² This written application was followed by a personal interview.

Monica, a graduate of VGH in 1967, remembers her application and interview process:

I don’t think it was very complicated; I’m trying to remember it now. I sent in my application, I had an interview. I am short, so that was a concern—you had to actually be 4 foot 11 to get in and I just sort of just made it. And I don’t know—I don’t think it was hard. We weren’t well off so it was certainly a choice that was inexpensive.⁶³

⁵⁸ “Entrance Requirements for Schools of Nursing in Canada,” Calgary General Hospital School of Nursing fonds., M-2456-19-288, Glenbow Museum Archives.

⁵⁹ Recruitment brochure, 1968, for the Holy Cross School of Nursing, Holy Cross Hospital School of Nursing fonds., BI-4-H761, 18, Glenbow Museum Archives.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Ibid.

⁶³ “Monica,” interview with author, January 17, 2011.

Following acceptance to the Holy Cross School of Nursing, students were told a “minimum of 60% is required to pass in each subject, with an average of 70% in each term.”⁶⁴ The school provided uniforms, but the student supplied shoes, stockings, and classroom attire. To cover the cost of textbooks and the library fee, the student paid \$100 per year. There was no admission or tuition fees, and students were paid an allowance after a probationary period (six months) of about nine dollars per month in the first year, eleven dollars in the second year, and fourteen dollars in the third year. “Service rendered by students during clinical experience cover[ed] part of their educational costs,”⁶⁵ as well as room and board and laundering of uniforms. Medical services were provided during the entire three-year program. Enrollment in nursing was provisional, and at any time schools reserved “the right to require the withdrawal of any student from the program who has not met the academic, clinical and personal standards as set out in its policies and criteria.”⁶⁶

Details of those academic, clinical, and personal standards of conduct were included in the student’s letter of acceptance, which was addressed to the student’s parents. A typical letter of acceptance from the Holy Cross School of Nursing in 1975 included the following information: “We are pleased to enrol your daughter into our fall class. We hope she will profit by and enjoy the program that has been planned for her. Perhaps a few words of explanation regarding some of our policies will be of interest and help to you.”⁶⁷ These “few words” let parents know that there was a thirty to forty percent attrition rate for students in the first year of the program. There were many

⁶⁴ Recruitment brochure, 1968, Glenbow Museum Archives.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Letter of Acceptance to Parents of Successful Applicants to the Holy Cross School of Nursing, 1975, Holy Cross School of Nursing fonds., HI.4 H761 3A, Glenbow Museum Archives.

reasons for this, but a significant one had to do with the degree of a student's conformity or resistance to the shifting but constantly enforced "rules" that shaped, directed, and controlled all aspects of a student's life. Parents were told: "The School does not send progress reports to students' parents. We acknowledge that our students are adults and we do not wish to interfere with their adult rights and privileges."⁶⁸

Rules and Regulations

Moulding the Student Body

The school may have recognized that students were adults *in theory*, but this was not the case in practice. Rules in the classroom, residence, and hospital regulated all aspects of the student's public and private life. Many students did not see the rules as an infringement on their adult liberties; in fact, for many the rules provided guidelines for becoming an adult. That was the way it was for Mona, a graduate of the Calgary General in 1967, who recalls:

That's the way it was. And they definitely had rules. One of the gals two doors down from me used to sleep in the nude on top of her bed. And they used to wake her up, make her put on pyjamas, and get inside the covers. Now, we had our own rooms with the door closed. You know, like, what difference did it make? It wasn't ladylike, and that was a big thing. I mean, we had etiquette ... in our school we had a dining room with china, silverware, and the whole works ... so that we would know how to be in society in terms of knowing what fork to use, that sort of stuff. And we were allowed ... to have our families come in and cook for them too.⁶⁹

To ensure that these rules were completely understood and agreed upon before the student accepted her position, parents and students were provided with "a Student Handbook [that] contains rules and regulations which are stipulated and enforced by a

⁶⁸ Ibid.

⁶⁹ "Mona," interview with author, January 18, 2011.

Student Honour Board” (which consisted of senior students).⁷⁰ In a student handbook from the Holy Cross School of Nursing covering the period 1959 to 1964, student activity was broken down into categories, specifying what a student could do and when, and how a student was to behave in the various locations and contexts in which they lived and worked. At the Holy Cross, students mostly had their own bedrooms. Here, “labels are always to be inserted in room door slots to indicate whereabouts of students.” In all locations, a student was to behave deferentially to authority and to patients: “students are expected to be respectful towards patients, visitors, doctors, sisters, instructors, fellow students and auxiliary personal. They should always stand when a supervisor, head nurse, instructor or doctor speaks to them.”⁷¹

Conforming to the rules also meant maintaining chastity. Students were told that they “may not marry during the course. If they wish to be married they must withdraw from the school ... [Further,] any misdemeanor committed by a student while away from the school, but which may affect its reputation, will be made a matter for disciplinary action by the faculty.”⁷²

A number of quasi-official organizational structures supported student surveillance. The Honour Board, made up of students and faculty, was “responsible for the discipline of the student body” and had “full authority to act.” As well, “members of the Student Nurses’ Association are on their honor to study the rules and regulations of

⁷⁰ Letter of Acceptance, 1975, Glenbow Museum Archives.

⁷¹ Letter of Acceptance, 1975, Glenbow Museum Archives.

⁷² Holy Cross School of Nursing Student Handbooks, 1959–1964, Holy Cross Hospital School of Nursing fonds., B1.4 H761-13, Alberta Health Services Archives, Calgary Alberta.

this school and residence and to abide by them scrupulously.”⁷³ As Shelley, a graduate of the Calgary General in 1966, recalls, there was purpose, even a need, for discipline:

S: And we had to attend chapel every morning before we went to class or to the units. We had to attend a chapel for about ten or fifteen minutes. We sang a few songs and had a reading and then we would disperse to go to our unit. But that was compulsory. Right up until the second year of my training. And then I think was not compulsory and I think eventually it dropped by the wayside. You know, those kinds of things, to me, it was a good thing because you have to get some discipline in your life to get anywhere in this world, it seems.

MS: It sounds like then that the guidelines in residence kind of reflected your own home values.

S: That’s right. They were, well, within reason of my home values. And there was a reason why, I mean, when they’re having—what was it—300 girls living in one residence at one time, it was very—I mean it would be very difficult to live without any sets of rules and regulations.

Moral and social regulation was also built into the architecture of the student nurse residence. Diana Dodd offers an interpretation of the architectural design of nursing school residences in Canada and its usefulness in enforcing student compliance with the rules of the residence. For example, a matron or house mother stood guard in her office at the main entrance through which all students must pass. That door was locked at curfew time and students had to ring the matron for admission, or risk breaking the rules by climbing up fire escapes, entering through open windows, or having a friend prop open an auxiliary door. Students were also not allowed to lock their doors. This allowed inspection at any time of the night or day. As Audrey, a graduate of the Holy Cross in 1961 remembered:

I’m not sure about any other nursing school, but the Holy at that time had complete control over us. They locked the door at 10:30 in the evening. You could get a late pass but you had to ring the bell and they would come

⁷³ Ibid.

and unlock the door and let you in. So it really was a very control situation.⁷⁴

Jana, a graduate of the Calgary General in 1974 recalled that parents had nothing to worry about in terms of direct supervision of their daughters:

We had house mothers I mean we had ... when we first started we had a curfew, they checked on us, the doors were locked, you only got in every half hour. I don't think they [parents] really worried.

Dodd explains that the most impressive nursing school residences were built specifically to house student nurses and were integral to the overall architectural style of the hospital complex. Dodd names these residences “women’s architecture as they constitute one of the first autonomous spaces for women in the built environment and symbolize the recognition of nursing as a profession.”⁷⁵ She explains that the style of the residence was part of a drive to promote the image of the hospital as a clean, efficient, and healthy environment staffed by well-trained, middle-class young women. As Mona, a graduate of the Calgary General in 1967 explained:

We had to be properly attired in residence. The telephones – we had a buzzer system in our room, and depending on the colour as to whether we had a visitor downstairs or whether it was a telephone call. And the buzzer would go and it would show us it’s a telephone call so there were two phones in the middle of the floor and I think there were 30 of us on a floor. So we could go down, but we had to either have our housecoats on, or be dressed. You couldn’t just go down in your pajamas, for instance, just in case a man might happen to be on the floor. Kind of Victorian, you know, in some ways. And of course the same one [student] that slept nude was always the one in skivvies going down to the telephone, and if the supervisors happened to catch her ... they’d come up and catch her and she’d be sent back to her room and told to phone back or whatever.⁷⁶

Dodd describes other “architectural remnants of surveillance” that promoted scrupulous adherence to the rules. These included “a mirror and seat strategically placed

⁷⁴ “Audrey,” interview with author, February 8th, 2011.

⁷⁵ Dianne E. Dodd, “Nurses’ Residences: Using the Built Environment as Evidence,” *Nursing History Review* 9 (2001): 186.

⁷⁶ “Mona,” interview with author, January 18th, 2011.

in the corridor between the hospital ward and the Pavilion Mailloux of l'Hopital Notre-Dame [in Montreal]. Nursing students straightened their caps in front of the large mirror before facing inspection from the supervising sister upon entry into the residence.”⁷⁷

Peggy, a graduate of the Holy Cross 1969 remembers the constant surveillance:

The thing that I was a bit surprised about was the fact that we used to have morning inspection of our uniforms. We sort of had to line up. I couldn't get used to that ... but we had to—in front of the cafeteria at whatever time it was, 7 o'clock, and we all had to line up in a straight line and we'd get inspected in terms of our caps being on right and our nylons and our shoes being white and everything being perfect, you know. So that was a bit of a surprise, but I think we all got used to it. I mean, that's the way it was.⁷⁸

Penny, a graduate of the Holy Cross in 1961, remembers that there were many vantage points for the observation of students that the nuns took advantage of, which also ensured that students knew they were being observed. Penny recalls her first week at the Holy Cross as she walked with friends through the tunnel that connected the residence with the hospital:

A bunch of us got together then, and Bev took us down through the tunnel over to supper. And I'm a redhead, Bev is a redhead, Marg Y. was a redhead and Marg S. was a redhead. And here we were, walking down the hallway and Sister Leclair was coming the opposite way and she said, 'Good evening, Miss L., Miss S., Miss S., Miss Y.,' and I thought, 'ah, she saw us for 15 minutes and she already knows who we are!' And we looked very similar—like, Marg Y. and I got mixed up quite a bit in training because we looked very similar. We had the same kind of red hair, the same blue green eyes and same kind of build. And so it was really interesting that our very first day, she knew exactly who we were. And so we thought, 'okay, here we are.' So that kind of set the tone, I think. You know, you thought, you can't get away with too much. If they say jump, I'm going to say, 'how high?' And get on with it.⁷⁹

⁷⁷ Dodd, “Nurses’ Residences,” 195.

⁷⁸ “Peggy,” interview with author, January 7th, 2011.

⁷⁹ “Penny,” interview with author, January 31, 2011.

For some students, despite the constant surveillance, the nursing residence was an improvement over conditions at home. Mona, a graduate of the Calgary General in 1967, came from a family of moderate means in rural Alberta. Mona was not disturbed by the rules of the residence, and remembered:

We had a laundry room on each floor but we didn't do, we did our own underwear and so on, but all our uniforms were done by the hospital. And our hats, everything was done by them. We didn't have to worry about that. They used to check our rooms to make sure our rooms were tidy every day.⁸⁰

Similarly, Pauline, a graduate of the Calgary General in 1965, recalled that having your own bed won her over:

I do remember in grade 12 going to the school of nursing for their open house. I liked it. I think it was just a variety and the openness, and our residence was new. We had our own rooms in that residence, we weren't sharing. I always shared at home with my sister, not only the bedroom, but the bed. I had a quarter bed. I mean there was never a choice.⁸¹

Despite the strictness, safety, or even luxury of the nursing school residence, living away from home offered a degree of freedom for young women not generally found within the broader working- and middle-class society.⁸² It was uncommon for young women to move away from their parents' home before marriage; nursing school was the exception because of the closed and cloistered environment that offered twenty-four-hour supervision of students.⁸³ Bev, a graduate of the Calgary General in 1966, recalls that her parents were not anxious about her leaving home at age eighteen:

Well, they—I don't think they minded me moving away from home and I think they thought probably it was very, I don't know if the word 'safe,' but I was in a residence and I mean, they were pretty strict with us, so I don't think they minded that and I only lived 40 miles away ... Oh, yeah,

⁸⁰ "Mona," interview with author, January 18, 2011.

⁸¹ "Pauline," interview with author, January 17, 2011.

⁸² Mona Gleason, "Psychology and the Construction of the 'Normal' Family in Postwar Canada, 1945–60," *Canadian Historical Review* 78, no. 3 (1997): 442–477.

⁸³ Gleason, "Psychology and the Construction of the 'Normal.'"

they were very supportive of it... Oh, my god, well, because you couldn't ... stay out past 10 o'clock at night and you had—you could have, I think it was one late leave. Or two. I can't remember how many late leaves we could have a month. Till midnight. I mean, you came in the front door and there was—the resident supervisor was right there because the switchboard was right there at the front door. So she—you had to sign in when you came in. So they knew I was—I was well taken care of. I wasn't, you know, going to be out—well, I don't know if they worried about me running around ... but they didn't have to worry about me. I guess that's the word I'm looking for.⁸⁴

While surveillance by many means served to enforce conformity, for some of the women interviewed, this surveillance ensured they would also be successful in achieving their goal of becoming a registered nurse. For Monica, a graduate of VGH in 1967, nursing school was a life of discipline, like the army, or like a convent. This kind of life, she explains, was what students needed to become professional nurses:

Well, certainly, you know, it was kind of like being in the army ... there were rules and you followed the rules and there was maybe merit to follow rules. None of us would ever be late for anything. We learned how to work. We learned how to prepare ourselves. We learned how to present ourselves. You know, all these things that were really important to them were maybe things that other kids didn't get the benefit of learning. As silly as it seemed to us at the time, it certainly prepared us to work ... certainly none of us [were] rebellious or any of that. So we certainly accepted it. So when we went to work, I don't know, maybe we learned a level of professionalism, or respect for our uniform, or respect for our job. It just seemed that nursing prepared us like no other job could have for just what comes next in life. Like, I mean, we all felt like it prepared us better to be mothers, even though we didn't learn child care or anything there, but you just learned organization and work ethics and learned not to panic.⁸⁵

Residential life was secure, familiar, and predictable; however, some students chafed at the constant monitoring and enforced conformity. As Mary Louise Adams contends, “Moral regulation limits the forms of expression available to us by masking difference with an illusion of social unity, the idea that what is regulated is in fact the

⁸⁴ “Bev,” interview with author, January 10, 2011.

⁸⁵ “Monica,” interview with author, January 17, 2011.

only order possible.”⁸⁶ For Audrey, a graduate of the Holy Cross in 1964, the regulated order was indeed the only thing possible:

At the Holy they [had] complete control over us. They locked the door at 10:30 in the evening. You could get a late pass but you had to ring the bell and they would come and unlock the door and let you in. So it really was a very controlling situation. I think in '62, things were much more controlled for nurses. I don't know any other profession that lived in residence and had such controls over them.⁸⁷

Anxiety about breaking the rules was well founded. Audrey understood that the Director of Nurses and the School Committee could “at any time terminate the connection of the student with the School for any of the following reasons: inefficiency, failure in examinations, physical or mental unfitness, conduct detrimental to the standards of the School, or failure to demonstrate qualifications necessary for a career in nursing.”⁸⁸ Failure to live up to the standards necessary for a career in nursing were clearly set out before the student entered nursing school, and there were plenty of opportunities to weed out candidates that might not fit. It is interesting to consider that in all my interviews, there was very little indication of serious refusal to live and abide by the governing rules, and governing discourses of the nursing school residence. As Gail explained, there appeared to be a rationale for the strictness of the residence:

G: You didn't fight that sort of thing in those days ... we had a matron and then we had a nurse that was available, any time of the day or night. We had our own doctor. You know, and it was all pretty controlled.

MS: I can understand when you say that having you in residence made you available for work, but what about the other regulations? The curfews and the behaviour and – what were they trying to—?

⁸⁶ Mary Louise Adams, “In Sickness and in Health, State Formation, Moral Regulation, and Early VD Initiatives in Ontario,” *Journal of Canadian Studies/Revue d'Etudes Canadiennes* 28, no. 4 (1993), 119.

⁸⁷ “Audrey,” interview with author, February 8, 2011.

⁸⁸ “Information for Prospective Student Nurses” brochure.

G: I think partly – and I don't know for sure—but partly because they felt they had a responsibility to the students under their care. So, responsibility not to have pregnant students and people out all night drinking. I think you would have been kicked out if you had done any of that. You wouldn't have been a student anymore ... I know you wouldn't have lasted and I also know you went through a physical by your own family doctor, then another physical by the doctor at the school before you got accepted. Then an interview. And I know if, say, you chewed your nails really badly, or if you were too fat, too short, maybe if you had really bad acne, you had some perceived problem, you would not be accepted. Of course, that would not happen now. Anybody would fight that on human rights ticket, but then they could really pick and choose who they wanted there, and if you stepped out of line, you would be asked to leave.

MS: What kind of people do you think they did want there?

G: I guess people who they could mold, who they could control, and who could work ... they would check your personality, check your references and your health. And that everything added up, then they had a pretty good chance of getting you through your three years and also supplying labour for the hospital during that time as well.⁸⁹

For those students who didn't comply, life could be made difficult. Gina, a graduate of Calgary General in 1964, remembers a friend who just couldn't fit in:

There were one or two of my classmates, though, well, more than that, actually, who did, who did get into trouble that way a lot ... At one of our reunions, this one in particular, who brings all the notes with her? Like someone kept scrapbooks, you know. And she kept a scrapbook and everything was Miss So and So, by your surname. You were never referred to as your first name. Ever ... So all of her notes would be 'Miss....' and it would go on and on, criticizing her with her housekeeping of her room, or getting in late or missing Chapel, that kind of thing. So she kept all of those notes and they're quite hilarious, really. But I think they really did pick on her. Once they realized that she—you know, people had a certain reputation, so they just kept at her. But no, I wasn't one of those.⁹⁰

Resistance was crushed quickly and effectively. Shelley, who graduated from the Calgary General in 1966, recalled:

We worked sometimes ten days in a row ... and it was justified in the end that some of the students got very disgruntled about these situations and

⁸⁹ "Gail," interview with author, January 21st, 2011.

⁹⁰ "Gina," interview with author, January 11, 2011.

one of the girls went forward to a radio station and actually made comments that we were just being used, we're not being remunerated for all the tasks and all the work we're doing. And actually she was called forward and they discharged her from the school. In later years they reconsidered what she did, after some time, and offered her to come back. I don't know if she really did or not. She was interviewed over the radio. So that was just such a distressing time, when that happened to one of our classmates, but on the other hand, they were very strict about the ways and disciplines they had and keeping us in line and then when they had people that were revolting they thought they would set us all back in our place and make us think twice before we did any such thing again.⁹¹

Being singled out as different from the rest of the student body could also have long-range consequences. Although the great majority of students were white, working-class or middle-class young women, there were exceptions, and in the case of "Miss A," a First Nations woman originally from Fort St. James, BC, the power that authorities had over students is demonstrated through reference to a comment on her graduation record, which was accessible to prospective employers. "Miss A." (pseudonym) had met the entrance requirements to St. Paul's Hospital School of Nursing and graduated from there in 1958. Mrs. J., an instructor at St. Paul's, summarized Miss A.'s overall performance as follows:

Miss A. appears to respond to associates and to environmental factors in regard to maintaining satisfactory grooming. Manner somewhat influenced by racial traits (Indian Origin) withdraws and not at ease with people generally, which influences her communications, verbal and written. Capable of giving Satisfactory and safe nursing care if understandingly supervised. Moreover, lack of organizing ability slowness to co-relate theory with practice and to adapt to new situations makes it unwise to place her in positions of responsibility. Consistently courteous and kind works well as a team member but satisfactory relationships maintained only by efforts made on the part of others. Does not appear to recognize her need for supervision.⁹²

⁹¹ "Shelley," interview with author, January 10, 2011.

⁹² A "Student History Card" from 1958, St. Paul's Hospital School of Nursing fonds., Box 224, File 5, Providence Health Care Archives, Vancouver BC. These cards gave the date of entry to the nursing program, date of graduation, and a list of all courses taken, with hours and letters grades for each. The report, which

Mrs. J. includes a summary of Miss A's strengths: "She is kind, courteous, slow and willing, capable of giving good nursing care." Her weaknesses are summarized as "theory background poor, reluctant to seek help, does not assume responsibility for her own growth and development, lacks ability to express herself, and a follower rather than a leader."⁹³ As Tania Das Gupta has argued "the ways in which power relations affect us depends on where each of us is located within society; that is, within race relations, class relations, gender relations and other sets of social relations ... a person who is considered 'white' in any society is defined in relation to who is considered 'not white'."⁹⁴ It is possible that indigeneity was also a contributing factor in that Miss A. stood out as different than her classmates because she was not white and not of European origin, and further, that this difference may have influenced the standard or focus of Mrs. J's assessment of her. Kathryn McPherson contends that the majority of nurses in the early and mid-twentieth century in Canada were white, Canadian born, European in origin, and that the "emphasis on the ethnic and racial superiority of nurses reinforced nurses' real or perceived status as an elite among the occupational choices for working women."⁹⁵ As McPherson further argues:

The virtual absence of women of colour in nursing's professional ranks was enforced both by federal immigration restrictions and by the racial discrimination practiced by hospital nursing schools. Whether Black women in Nova Scotia, Japanese Canadians in British Columbia, or Native women anywhere, women of colour rarely were accepted in training programs on the grounds that White patients could not be entrusted to the care of non-White nurses."⁹⁶

could be accessed by future employers, also includes the headings "Strengths," "Weaknesses," and "Health," as well as a character evaluation of the student.

⁹³ Ibid.

⁹⁴ Tania Das Gupta *Real Nurses and Others: Racism in Nursing* (Black Point, NS: Fernwood Pub, 2009): 23.

⁹⁵ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing 1900–1990*, (Toronto: Oxford University Press, 1996): 17.

⁹⁶ Ibid., 118.

For Jana, a graduate of the Calgary General Hospital in 1974, a student such as Miss A. would probably have stood out because of her racialized origins:

We were pretty well all WASPY. One of our classmates was Métis but everyone else was a WASP, through and through. I think it was just who was applying. I think back then it was just pretty WASPY. We didn't have a lot of people applying to our school who were non-WASP, so it probably wasn't until people were immigrating into Canada and having kids that we started seeing them in our school in the 80s.⁹⁷

Thus, it was probably not so much who applied to nursing school, but rather, who was accepted that shaped and was shaped by governing racial norms.

Karen, who graduated in 1961 from St. Paul's Hospital School of Nursing in Vancouver, also comments on the racial homogeneity of the student population:

We were about 110 in our class. We had a very cohesive group ... some of them came from much different backgrounds than my own, but many of them came from backgrounds like myself. So over all I would say it was a very good class, I would say about 90 percent of the girls had much in common.⁹⁸

While racial exclusion created barriers for women wanting to become nurses, racial homogeneity also contributed to a shared sense of belonging and community.

Betty, who graduated from UBC in 1967, explained to me:

We had three in our class from a Japanese background. Two Japanese and one Chinese. So they had a difference because they were immigrants [although they were Canadian born], or their parents [were]. And the two Japanese had the issue of internment, or not personally because we're younger than them, but in their family. I know the one set had definitely been displaced to Vernon. And the one who is of Chinese origin had a lot of issues around cultural expectations [about] her behaviour and who would be her friends and her boyfriends, and things [like that] they had a different path to follow than I did for instance, the dominant culture.⁹⁹

⁹⁷ "Jana," interview with author, April 8th, 2011.

⁹⁸ "Karen," interview with author, January 26, 2011.

⁹⁹ "Betty," interview with author, January 14, 2011.

As Alvin Finkel has documented, during the Second World War, schools of nursing across Canada were asked to dismiss students with Japanese ancestry, including Canadian citizens. Some schools of nursing resisted, including UBC, but others conformed.¹⁰⁰ Racialization was pervasive, Finkel explains: “African-Canadian women had to wait until the 1960s to be admitted to nurse training ... before the sixties, the numbers of African-Canadian women, like the number of Native women admitted to nursing programs, were quite modest.”¹⁰¹ As small numbers of students from non-white backgrounds were admitted to schools of nursing, it was assumed that these nurses would work among people of their own “race.”¹⁰²

Parents did not necessarily disagree with systems of racialization. Conformity to gender, race, class, and cultural norms were, in fact, a desirable feature of nursing school. As Susan Anthony and Janet Landeen have argued, “Students were taught nursing priorities, relationships, and values”¹⁰³ that reflected attitudes in the broader Canadian society, including attitudes toward race. As Mary Louise Adams claims, “What are taken for ‘normal’ are, for the most part, representations of dominant interests ... activities of moral regulation help establish dominant modes of being as not only legitimate modes but as desirable ones.”¹⁰⁴ These interests were those of the dominant, white, Christian community.

¹⁰⁰ Alvin Finkel, *Our Lives: Canada after 1945* (Toronto: Lorimer, 2012).

¹⁰¹ *Ibid.*, 12.

¹⁰² McPherson, *Bedside Matters*: 118.

¹⁰³ Susan E. Anthony and Janet Landeen, “Evolution of Canadian Nursing Curricula: A Critical Retrospective Analysis of Power and Caring,” *International Journal of Nursing Education Scholarship* 6, no. 1 (2009): 3.

¹⁰⁴ Adams, “In Sickness and in Health,” 119.

Summary

In this chapter I have argued that, although nursing students faced a strict set of moral and social regulations upon entry to nursing school, these systems of regulation were not markedly different from the regulation of young women from similar class, cultural, religious, or racial backgrounds in the broader society. While it was unusual for young single women to live away from parental supervision, the rules and regulations of nursing school, clearly provided to parents and students upon admission, gave parents confidence that the supervision of their daughters would mirror the standards of conduct of most working- and middle-class homes. The close supervision of students in all aspects of their private and public lives created unique opportunities for young women to advance their education, achieve social status, and gain employment skills while allowing an unusual degree of freedom from direct parental supervision.

I have also argued that opportunities for advanced education were limited for young women from working- and middle-class families in this period. The three-year diploma program offered an affordable and accessible opportunity for working-class women to obtain advanced education and a professional credential, while the four- or five-year university programs offered chances for rapid upward career mobility and were one of the few professional university programs open to women. The rise of the welfare state, and the rising status of a university education, coincided to provide unique opportunities for women seeking to either augment the family income or build a professional career. At the same time, admission to nursing school was limited by the ability of the dominant class to enforce requirements that marginalized applicants that

were not white, Christian, single, young, or possessing suitable character references or who were not able-bodied within a strict set of physical or psychological parameters.

Finally, I have argued that, in addition to the affordability of a nursing education, the social status of nursing, and opportunities for secure and plentiful employment in nursing, could be seen as a legitimate preparation for marriage and motherhood, a legitimate reason to delay these roles, or, the opportunity for a professional career. The following chapter presents the broader context of working- and middle-class women's lives in Canada in relation to marriage, motherhood, and paid employment. Nursing offered a number of opportunities for women to participate in the new consumer society, to gain a new sense of status through paid employment, to gain leadership and management skills, and to perform an essential social service. At the same time, the workplace was not conducive in this period to long-term employment for married women, and it did not accommodate the needs of married women with children. Interviews reveal a shifting demographic of employed women and the challenges they presented and faced as a new generation that claimed their rights as women workers and professionals.

CHAPTER FIVE

Working Motherhood

I think [my children] probably thought that I was just a 'little workie.' I'm a 'little workie' at home and I'm a 'little workie' at the hospital. My daughter was very surprised, she said, when we first went to the hospital where I was working. She said, 'You went behind the desk, at the nursing station!' People come to me in my job as a resource. They're always coming and asking me questions, I'm always doing things for the staff. She was surprised that people would come to me and that so many people knew me and so many people would use me as a resource. I don't think the kids had any idea that their mom had a fairly significant role in the hospital.¹

Dora, graduate of the University of British Columbia School of Nursing, 1977

Women interviewed in this study came of age, and became nurses, wives, and mothers, during the 1960s and early 1970s. These women were members of what has come to be known as the “baby boom” generation.² It was during their growing-up years, after the Second World War, as Tina Block and Mona Gleason explain, that Canadians struggled to re-establish what was considered the social “stability” of the white, Christian family in the face of changing assumptions about women’s total commitment to marriage and motherhood.³ Block describes how the “rhetoric surrounding the ‘ideal family’ played a powerful role in Canada’s post-war culture ... families were made up of homemaking wives, bread-winning fathers, and obedient children, all happily living within the bounds of their age- and gender-appropriate roles.”⁴ It was also in this post-war society that the women interviewed, then in their late teens, chose to enter nursing.

¹ “Dora,” interview with author, January 19, 2011.

² Bryan D. Palmer, *Canada’s 1960s: The Ironies of Identity in a Rebellious Era* (Toronto: University of Toronto Press, 2009).

³ Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999); Tina Block, “‘Families That Pray Together, Stay Together’: Religion, Gender, and Family in Postwar Victoria, British Columbia,” *BC Studies* 145 (2005), 31.

⁴ Block, “Families That Pray Together,” 31.

During this same period, the nursing profession moved forward to adjust to changes in Canadian health-care delivery, including new medicines, surgeries, and technologies. As nurses adjusted to these influences, they were, like many other women, undergoing a change in their relationship to work, marriage, and motherhood. Rather than being passive targets of this change process, as has been described in some histories of nursing,⁵ stories told by women in this study reveal a more complex picture. In this chapter, I highlight the complex ways in which women in nursing benefited from the opportunities that employment offered, but also struggled to balance competing domestic responsibilities at a time when, for the majority of working- and middle-class women, paid employment was not fully accepted and women's unpaid caregiving roles also positioned them within a subservient gender hierarchy.

In this transitional period, women were becoming essential productive workers, while their primary role continued to be governed by discourses of domestic responsibilities such as housework and child care. For nurses, this was, and is, doubly so. The association of nursing with paid caregiving, and the lack of accommodation in the workplace for nurses to provide the quality of professional care dictated by their professional standards of practice, created challenges and contradictions as nurses struggled within an expanding and increasingly complex and demanding work environment. Simultaneously, paid caregiving meant that many nurses also confronted considerable obstacles to maintaining the quality of family care that was expected of

⁵ See Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987); Deborah Simonton, "Nursing History as Women's History," *International History of Nursing Journal* 6, no. 1 (1999): 35–47; Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Charlotte NC: University of North Carolina Press, 2000).

married women with children. As Susan Reverby has argued, because caring has been associated with women's "intuitive" way of being, it was not valued as a unique set of skills or a particular knowledge held by women or nurses. Thus, in an often-quoted phrase, Reverby claims that "nursing's contemporary difficulties are shaped by the factors that created its historical obligation to care in a society that refuses to value caring."⁶

As nurses struggled to meet competing demands at home and in the workplace, they developed and employed a number of innovative attitudes and approaches that challenged governing discourses related to women and work, nursing, and organized labour, as well as the rising discourse of a new kind of professionalism based on academic credentialing. Through these innovative approaches, nurses drew attention to the realities of working motherhood, including entrenched workplace inequality for the majority of working- and middle-class women.

In support of these claims, in Chapter Five I present three main arguments. First, I argue that while it was an accepted norm that working- and middle-class women worked hard, what was *not* the norm was that these women worked in both the paid and unpaid labour market simultaneously, while also balancing the responsibilities of marriage and motherhood. Nurses were unique in creating new ways of organizing these double labour demands, and as a result, highlighted issues of concern for women in the broader social context. Second, I argue that while nursing offered many opportunities for married and single women, there were challenges in the workplace due to the lack of accommodation for working women's domestic responsibilities, particularly those with children. Nurses did not passively accept workplace limitations but instead, used both conformity to, and

⁶ Reverby, *Ordered to Care*, 290.

resistance against gendered norms to re-shape their workplace experience. Finally, in re-shaping workplace experiences, nurses drew on liberal feminist ideologies of equality in the workplace and also social or labour feminist ideas of the right to fair labour practices but also accommodation for women's unpaid care giving roles. Thus, both second-wave liberal feminism, as well as labour feminism were prominent tools for negotiation and provided a means for women to theorize gender oppression. As nurses took up various feminist ideologies in different ways, gains were made, but divisions along class-based lines also opened up, pitting unionized nurses against so-called professional supervisory and instructional staff.

Motherhood Challenged: The Canadian Context

As Joanne Meyerowitz contends, not all women and families fit one demographic profile. In the United States, “in the years following World War II, many women were not white, middle-class, married and suburban; and many white, middle-class, married, suburban women were neither wholly domestic nor quiescent.”⁷ Valerie Korinek explains that diversity also existed in Canada, but Canadian families were, on the whole, less affluent than families in the United States. Increasingly, even for middle-class families, two incomes were required to maintain emerging standards of material consumption.⁸

As the number of working wives and mothers rose, tensions grew “between the valorization of the stay-at-home wife and mother and the new economic reality that saw waged work increasingly become the norm for women.”⁹ Veronica Strong-Boag observes that “the appearance of growing numbers of married women in the paid labour force met

⁷ Joanne J. Meyerowitz, *Not June Cleaver: Women and Gender in Postwar America, 1945–1960* (Philadelphia: Temple University Press, 1994), 2.

⁸ Valerie Joyce Korinek, *Roughing It in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties* (Toronto: University of Toronto Press, 2000).

⁹ *Ibid.*, 7.

with a mixed reception in the mass circulation press. There was little indication that Canadians were about to reconsider traditions that relied on a relatively strict division of labour making women ultimately responsible for domestic duties and men for breadwinning.”¹⁰ A 1961 *Vancouver Sun* article for example, reported that a federal inquiry into reasons for unemployment in Canada placed the blame for men’s high unemployment rates on working women who did not *need* to work. Dr. R. Warren James, researcher for the inquiry, vilified married women who took work from single, divorced, and widowed women, “to say nothing of heads of families.” He further warned that “employers as well as government have a duty to consider seriously their responsibility ... the mother who works to pay for a second car, or an oversized mortgage, or for pastime only, presents a serious enough social problem even in times when work is plentiful.”¹¹

Women were criticised for taking work from men, but, in fact, it was often difficult for single or married women to find work, and when they did, it was often low paying and demeaning. As Annis May Timpson explains, “Debates about women’s rights at work and the gendered dimensions of employment inequality were notable and contested features of Canadian political discourse throughout the second half of the twentieth century.”¹² Public concern about women’s employment inequality was manifest in the political arena in the form of the Royal Commission on the Status of Women (RCSW). This federally appointed commission, set up to look into the conditions of women’s lives in Canada, conducted public hearings that documented gender

¹⁰ Veronica Strong-Boag, “Canada’s Wage-Earning Wives and the Construction of the Middle Class, 1945–60,” *Journal of Canadian Studies/Revue d’Études Canadiennes* 29, no. 3 (October 1, 1994), f-21.

¹¹ *Vancouver Sun*, February 9th, 1961.

¹² Alice Timpson, *Driven Apart: Women’s Employment Equality and Child Care in Canadian Public Policy* (Vancouver: UBC Press, 2001), 3.

discrimination against women at all levels of society. The commission concluded that less than four percent of managers were women; that although laws across the country prevented gender discrimination in pay, the majority of women made less money for the same work as men; and that two-thirds of people on income assistance were women.¹³

While the feminist movement also brought attention to women's unequal status in the home, workplace, and society, that movement alone, according to Strong-Boag, does not explain the sharp increase in women's paid employment in the 1950s and 1960s. According to Strong-Boag, women were responding not just to feminism and to gender inequality, but to broader social changes, strongly influenced by more favorable economic conditions, which meant an increase in employment of the kind of work already done by women, including nursing, social work, and teaching.¹⁴ As Strong-Boag observes, "The desire to take advantage of unprecedented opportunities for mass consumption further mobilized women after the war. By 1951 the trend was clear: women, and especially married women, were entering the labour market in rising numbers."¹⁵ By 1961 the number of employed wives had doubled and represented almost half of the female labour force.¹⁶

Having a second income was increasingly important to rising expectations about middle-class economic status. In 1969, *Chatelaine* magazine confirmed this trend and presented the results of a questionnaire completed by 11,000 women from all regions of Canada. The majority of these women, who described themselves as coming from

¹³ Royal Commission on the Status of Women in Canada, *Report of the Royal Commission on the Status of Women in Canada* (Ottawa: Information Canada, 1970).

¹⁴ Strong-Boag, "Canada's Wage-Earning Wives."

¹⁵ *Ibid.*, f-9.

¹⁶ Strong-Boag, "Canada's Wage-Earning Wives."

“moderately comfortable financial circumstances,”¹⁷ stated that they did not work outside the home, but that if they could, they would choose marriage, motherhood, *and* a career. In this survey, these same middle-class women advocated for government-supported daycare, equal access to employment, equal pay, government-supported birth control clinics, and greater access to abortion and divorce.¹⁸

Nursing and Motherhood: A Productive Link

In the 1960s and 1970s, women were expected to fulfill their primary social role through marriage and motherhood.¹⁹ Some of the women interviewed explained that nursing prepared them for this role in a way that no other training could have. Monica, a graduate of the Vancouver General in 1967, remembers that nursing and motherhood were a natural fit:

It just seemed that nursing prepared us like no other job could have for just what comes next in life. Like, I mean, we all felt like it prepared us better to be mothers, even though we didn't learn child care or anything there, but you just learned organization and work ethics and learned not to panic ... Well, I mean, motherhood just comes at you. It really does. And there is no preparation *per se* for it, but you just learn different things from different angles all the time. And good or bad, illnesses and all sorts of crises, and I just think you just kind of learned a cool head and how to deal with things [as a nurse].²⁰

Preparing women for their role as mothers was an acceptable function for nursing programs in the 1960s and early 1970s, as Dr. J.D. Mills divulged at a presentation for Mount Royal Junior College's Department of Nursing Education in Calgary in 1968: “It has been quoted that the primary goal of nursing students is marriage rather than a full-time career ... The prospects of marriage and children enter every aspect of nursing, and

¹⁷ Korinek, *Roughing it in the Suburbs*, 270.

¹⁸ Meg Luxton, “Feminism as a Class Act: Working-Class Feminism and the Women's Movement in Canada,” *Labour-Le Travail* 48 (2001): 63–88.

¹⁹ Katherine Arnup, Ruth Roach Pierson and Andrée Lévesque, *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (New York: Routledge, 1990).

²⁰ “Monica,” interview with author, January 17, 2011.

therefore no aspect of the profession can be completely understood apart from the influence of marriage plans.”²¹

Nursing fit with motherhood in a way that other female occupations did not. Joan, who graduated from the Vancouver General Hospital School of Nursing in 1971, explained that she had wanted to be a photojournalist, but decided that this goal would not be compatible with marriage and motherhood:

If I’d become a photojournalist ... I wouldn’t think I’d have been able to—I mean, it was a decision my husband and I made that he had the career and I had the job. So I followed him around, and if I had done much differently, I don’t think I could have done that—raised our sons and stayed with the family if I had traveled about. Thank goodness I enjoyed nursing, that I was able to do what my husband and I decided we would do and support his career.²²

Joan was able to work as a nurse following marriage in part because the demand for nurses meant that women could move in and out of nursing jobs with ease. Night shifts, split shifts, and twelve-hour shifts meant that nurses could fit childcare into a dual-income schedule. For Anne, a graduate of the Calgary General in 1964, nursing met her family’s need for additional income allowed her to fit her schedule around her husband’s:

I think you worked because you needed the money. You worked and you were fortunate to have a job that was flexible and you could enjoy. You could choose where you worked.²³

The unambiguous suitability of nursing as women’s work decreased some men’s (and husbands’) resistance to married women’s employment. Nursing was a respectable second source of income for the family economy and allowed working-class families to consider the purchase of middle-class consumer items such as a family home, and for

²¹ Speech presented to faculty and students at Mt. Royal College, Department of Nursing, 1968, Calgary General Hospital School of Nursing fonds., M2456-395, Glenbow Museum Archives, Calgary Alberta.

²² “Joan,” interview with author, January 25, 2011.

²³ “Anne,” interview with author, January 18, 2011.

middle-class families raise their standard of living. For example, as Jackie, a diploma-educated front line nurse explained to me:

We wanted to have our own house and we were living in rental places and the ones we were in were not terribly wonderful and I think at that point, most of us young couples, we wanted our own house, that was the big thing you were saving up for ... In the couples that we socialized with, regardless of what they were doing, they were saving up money to buy a house.²⁴

Although nursing provided an opportunity to save for a house and other desirable commodities, some women were conflicted about their paid employment because it took away from their time with children. Shelley, a graduate of Calgary General in 1966, reflected on these issues as she wrestled with how or whether to combine work, marriage, and motherhood:

Well, back when I was first starting to be a homemaker and a mother ... home values were more important. Mother had a role to play. 'This is what mother should be,' whatever. And I don't know if being a full-time employee was on that list. Not likely, right? But as time goes on, people had that thing that if you don't spend this time with your children, they're going to grow up and they're going to turn into renegades or criminals, or whatever. That mindset that 'mother's place is in the home.' But as time goes on and our cost of living and society, whether they dictate you should have this, you need this and you need that and this and that, well, let's face it, how are you going to pay for it on one person's salary coming in? ... and it just sort of meant pressure on the housekeeper to get in there and help pay for whatever.²⁵

Once a woman made the decision to work, jobs in nursing were plentiful in the burgeoning public service sector of the 1950s, 1960s, and early 1970s. Alice Baumgart, who has examined trends in nursing labour history in the post-war period, explains that, "although the total Canadian labor force grew 33% between 1961 and 1971, the health sector grew by more than 60%. Approximately 75% of the new jobs were in the hospital

²⁴ "Jackie," interview with author, January 31, 2011.

²⁵ "Shelley," interview with author, January 10, 2011.

sector, with registered nurses (RNs) claiming a significant share.”²⁶ There were really no other health-care workers who could provide the same services.

As Baumgart explains, most of the work that women were paid to do did not have the portability, diversity, or flexibility that nursing offered. Val, a graduate of UBC in 1967, remembers, it was hard to *avoid* job offers:

I could have gone into anything really. There was tremendous opportunity in public health. Any place in the hospitals. Like, the jobs were a dime a dozen. You could get anything. There was no such thing as being interviewed by a committee. You know, they sort of grabbed at you the minute you put your foot in the door. Oh, good here comes a likely body. Grab! Snatch!²⁷

Part-time positions, although uncommon in the early 1960s, worked well for childcare when a husband was working full-time. Audrey, a graduate of Holy Cross in 1964, recalled:

Actually, working part-time was fine. As a matter of fact, one of the things about nursing that I really appreciated is that you could work part-time or full-time or whatever to suit your lifestyle. My husband was home in the evenings and I worked evenings. When I first started back I worked evenings so I could be home at noon when the kids came home for lunch. And we just lived a couple blocks from the school so they’d come home for lunch every day. And then I had a neighbour that the kids would go to until my husband got home. It worked out beautiful. It was just fine.²⁸

Nursing also worked out “just fine” when motherhood was perhaps not as absorbing a career as was anticipated. Gina, a graduate of the Calgary General in 1964, recalls that after her first child was born in 1979, she had been working full-time and returned to work after six months. She did not need to work, but she was thirty-six years old and married a second time:

²⁶ Alice J. Baumgart, “Hospital Reform and Nursing Labor Market Trends in Canada,” *Medical Care* 35, no. 10 Suppl. (1997): OS124.

²⁷ “Val,” interview with author, January 19, 2011.

²⁸ “Audrey,” interview with author, February 8, 2011.

G: I thought that staying at home with my child when he was born in '79 would just—I just looked at women who were at home on my street with their children, and I thought, this is going to be lovely. I could hardly wait. And, although it was hard to go back to work and leave him with a home daycare provider, I could not—I did not like being at home. Because I did not feel I accomplished—I mean, I look back on it now and I think, hmm, you know, what if, what if, what if. But that's just the way I was. I still think I was a good mother. But—

MS: Well, did you find it a conflict at all?

G: Oh, yes. Oh, yes, yes. But I wanted a certain—I wasn't willing to give up a certain lifestyle. I could say that would be part of it. And I felt so much fulfillment at work.²⁹

Similarly, for Dina, a graduate of the Calgary General in 1964, nursing allowed her an avenue of escape from the relentlessness of motherhood:

I was never one of these people that would do well at home. I didn't fit in with being a housewife. And I didn't know that about myself until, for instance, one time when my youngest was four years old I went to the director of nursing who was a lovely lady, at the public health services, and I said, 'I think I'm going to take a couple months off this summer and I'm going to seriously think about quitting work'... [At] the end of two months, I'm not kidding, it rained that whole summer. Every time I blew up the rubber ducky to go take the kids swimming, it rained. It was a terrible summer. And that's when I knew that I wasn't able to—I couldn't do that [quit work].³⁰

Nursing also had the benefit of being a portable occupation, and nurses were in demand in all communities across Canada and could also work in the United States, Britain, New Zealand, and Australia. Women could move in and out of nursing jobs with ease, following a husband's career or an adventurous whim, although they did not retain any seniority when they moved, and there were no maternity, sick leave, or disability benefits.³¹ As Wanda, a graduate of the Vancouver General in 1969, who left Canada and

²⁹ "Gina," interview with author, January 11, 2011.

³⁰ "Dina," interview with author, January 18, 2011.

³¹ Mark Roth, "The Gendered Workings of Class in Postindustrial, Service Sector Capitalism: The Emergence and Evolution of the British Columbia Nurses Union, 1976–1992" (Master's Thesis, Simon Fraser University, 2008).

moved to Boston with her husband explained to me:

Actually because my husband was going to graduate school and I was sort of there by myself and I didn't know anybody and so I met an obstetrician and said, 'you know, I'll come and work for you in your office for free until I get this darn visa.' So I worked in his office doing basically antenatal care for six months or so until I could work, and then I think I kept working for him on the weekends when I wasn't working my shift. Then I went from Boston—I was two years in Boston—and then we moved to Montreal and I right away got a job at the Royal Vic there, also in labour and delivery. And I had a—my first child was born in Boston—and my dream was I would go into labour on a shift and have my baby and then just carry on working.³²

Part-time Work

Nursing work was plentiful and portable, but before the mid-1960s, nurses worked mainly full-time. Penny, a graduate of the Holy Cross in 1961, remembers that although married mothers with children were encouraged to stay in nursing, employers did not take into account the realities of pregnancy, childbirth, and childcare. Penny remembered:

At that time, when you were pregnant, you had to stop working at six months. You couldn't work past your six months. And even me, who was—at that time I was the pediatric coordinator, so I wasn't doing any heavy lifting or anything like that, that would maybe prevent a pregnant woman from working at the time, but they said, no, so I had six weeks of mat leave and then when I was ready to go back to work, I went part-time. And at that time also, part-time was not so easily acquired. You had to really convince them that you could work part-time. I don't know why they didn't want part-time people.³³

Part-time positions, when available, could work well, but organizing childcare during work hours remained a challenging woman's responsibility. The resistance by employers to part-time work in nursing can be linked in this transitional period to the very recent time when nurses were primarily single women with no direct childcare responsibilities.

³² "Wanda," interview with author, January 8, 2011.

³³ "Penny," interview with author, January 31, 2011.

Working part-time was considered “unprofessional,” within traditions of nursing which valued total commitment, an almost vocational commitment from its members. Within this tradition, the nurse devoted her life to the service of nursing and put her patients before her “personal” life. Penny’s frustration with these demands is evident:

When I first started, part-time jobs were not something that was common, and neither were permanent shifts. You worked days, evenings and nights most often. There was none of that permanent evening shift, permanent night shift, unless you really had to work for it and convince the person that you could do the permanent shifts and still keep up with the meetings and things that were going on. Like I remember when I first started at the Children’s Hospital too, my mom had just had a heart attack at the time, and so she was going to the Coronary Cardiology Rehab, and I was the one that had to drive her and stay with her and do whatever, and part of the job, because I was working weekends, they required that you come in to the different meetings that were going on during the week. Yeah, you got paid for them but you still had to go so that meant I’d have to get a babysitter or find somebody to take my mom to the place that she was going to. And so my attendance at those meetings weren’t the best. And they sort of let me know that, that in the next year that my meetings should be ... better attended.³⁴

Flexibility and Overload

The chronic shortage of nurses meant that not only were the hours of work inconvenient, because nurses had to cover long shifts and were needed twenty-four hours a day, but the work itself was hard. While many diploma-educated nurses worked in the same hospital in which they trained following graduation, many also married and followed their husband’s career to new cities. Starting work in a new location could create added stress for new nurses because the prevailing attitude in nursing was (and still is) “sink or swim.”

Taking on responsibilities beyond your ability or authority was (and is) considered by many nurses, a demonstration of good nursing instincts. A self-sacrificing,

³⁴ “Penny,” interview with author, January 31, 2011.

non-complaining attitude was (and is) a strong value in nursing. This value was (and is) inculcated in nursing school and continued as a regulating discourse following graduation and entry to the “real” world of nursing work. Under this ideology, new nurses were often put in dangerous situations, causing them to overstep their experience and ability to provide safe care. As Karen, a graduate of St. Paul’s in 1961, remembers, you took working conditions as you found them and adjusted:

I graduated in September of ’61 and I was very excited because I had two job offers and one was at VGH and one was at Burnaby and I took the Burnaby one because it was a smaller hospital and I worked on Medical there for six months and I loved it, but I recall one thing for sure. I remember this very well. We had a lot of responsibility right off the bat. I was the only nurse on nights on the medical ward and I had probably two people with me, a nurse’s aide and a practical nurse and I remember that very well, how intimidating that was at first. But I fell into it quite well.³⁵

Not all nurses could (or can) adapt to such adverse working conditions. Cora, a graduate of UBC in 1971, remembers that the prejudice against university graduates in these decades, based on the belief that they were not “real” nurses, created additional hardship and anxiety when starting on an unfamiliar unit. She recalled that, as a new graduate,

It was hard, because, like at that time, they didn’t have any sort of—I think now they have a kind of an easing in of new grads ... preceptorship, or something ... at that time it was just, well, go set up a dressing tray, just go in the dressing room and set up a dressing tray. And I didn’t know where anything was or what the specific protocols were and so it was just, yeah, and there’s your patient and you were sort of on your own. It was actually really stressful. In fact, yeah, that summer was terribly stressful and I was just, I would wake up early, early in the morning, long before the shift was going to start and I’d just start worrying and worrying. And then I’d be fine all during the shift, and then I’d come home and I’d just collapse and cry until bedtime. It was terrible.³⁶

³⁵ “Karen,” interview with author, January 26, 2011.

³⁶ “Cora,” interview with author, February 18, 2011.

Motherhood: Making it Work

While nursing offered a degree of job security and plentiful employment, as well as a respectable occupation for women, including married women with children, the idea that women's primary role should be within the home prevailed.³⁷ Rona's experience in 1965 suggests how these attitudes affected her experience of work, marriage, and motherhood:

I married a fellow [in the mid-1960s] who did not want me to work. But I did. It was very important to me. I'd worked hard to get my RN and I worked for a year ... then I had my first baby. And I always worked but he did not want me to work. And in order to work I had to do everything first of all at home...after I had the baby I worked casual or permanent part-time and I did that on and off in between having my babies ... but I had to get all the work done at home. I usually worked the afternoon shift so everything was done. The meal was ready for the evening. Anything the kids needed was organized ... so it wasn't easy, but that's what I did and that kept him happy, as long as everything was done that needed to be done. He didn't like it, but we came to that—as long as I'd done things. It was hard, some of it was hard and I was tired. And I'd get home—I usually worked the afternoon shifts, so I'd get home at midnight ... and I might have to be up with the kids at night time, right? And still be up in the morning, so there was never any, 'boy, you did a good job' or 'you must be tired.' There was never any of that.³⁸

In addition to unhelpful husbands, another important consideration, and a source of condemnation, for working women with children was the issue of daycare. For example, in the 1960s and early 1970s, debate raged in "popular psychology" magazines about whether children should be "left" in daycare while mothers worked. Women's demands for daycare generated fears that women were abandoning their commitment to their role as mother in favour of social status and monetary gain. As Dr. D.C.T. Bullen, a school board trustee in Comox, B.C., remarked in a 20 December, 1966, *Vancouver Sun* article about the need for nursery schools: "Nursery schools are being promoted by

³⁷ Strong-Boag, "Canada's Wage-Earning Wives."

³⁸ "Rona," interview with author, January 25, 2011.

women who have forgotten their roles as mothers ... keep it up and we'll have Huxley's *Brave New World* very soon."³⁹ (The allusion to Huxley's *Brave New World* was targeted at women who chose daycare and left their children with "strangers.")

Another opinion piece, which ran in the *Vancouver Sun* on 21 January, 1966, responded to an earlier column that had attacked "the whole concept of day care." In "Nonsense About Day Care Centres," Joan Wallace, member of the Federal Advisory Council on the Status of Women, began with the challenging question: "Would Mary have sent the Baby Jesus to a day care centre?" She argued against the popular belief that daycare was harmful to children and that it was "provided solely for the benefit of the mother," claiming that this belief was "based on myths perpetuated by male chauvinists whose aim is to keep women in the home." Wallace explained that Mary and Joseph probably worked at home and had relatives nearby to care for Jesus. She addressed the charge, made by an opponent of daycare, that if Mary had sent Jesus to daycare, "her son might not have become the symbol and ideal of love, both human and divine, which He has been for our civilization for 20 centuries." In defence of women's need for daycare, Wallace prophesized: "Day care is not a luxury but a necessity. In the not-too-distant future it will be an integral part of our educational system available to all just as high schools, once reserved for the wealthy, are now open to everyone."⁴⁰

For Jackie, who graduated from the Calgary General in 1964, choosing daycare was a luxury. First, you had to find one, which was a major ordeal for women in the late 1960s:

There was nothing available to us. The hospital didn't provide anything ... you just didn't know who you were leaving your child with. I got, I was

³⁹ Aldus Huxley, *Brave New World* (New York: Harper Collins Publisher, 1932).

⁴⁰ *Vancouver Sun* 21 January, 1966.

very lucky that I had a wonderful lady to leave my kids with, but there were some horror stories that I do remember, where they shouldn't have been at the place where they were, or some parent was caring for way too many kids, that sort of thing. And it wasn't licensed at that point or anything either, and it was just somebody decided they wanted to make some money on the side and took kids in.⁴¹

In addition to low pay, lack of daycare, and long hours, lack of maternity benefits was another source of frustration. Regardless of how much seniority she had, if a nurse resigned for any reason (including child bearing), she started at the bottom of the seniority list when she returned to work. When maternity leave was granted, it was short and conditional, often only a month in duration. Wanda, a graduate of Vancouver General in 1969, remembers trying to work after the birth of her first child in 1970:

I remember working evenings and weekends in labour and delivery, I suspect it was part-time. And let me tell you how horrible it was being a breastfeeding mother going back to work in those days. Because it was so busy so I'd sit in the john on the toilet eating my sandwich and pumping my breasts. That was the only facility there was and, of course, nobody breastfed in those days. I was all alone and when I had to work late, overtime, the whole front of my scrub suit would be soggy with milk.⁴²

Similarly, Shelley, a graduate of the Calgary General in 1966, remembers trying to recover from the birth of twins and returning to work after one month:

My son was born in March of 1969. He was a premie and he was in intensive care, so I had to quit work because I had him prematurely. I took a month off and they allowed me to do that but then they encouraged me to come back to work. I had only been off a month after losing a child—I had twins—and I just had my son who was a premie of 2 pounds 10. So I went back to work in one month and I went to see him during my breaks and after work. When he was three weeks old I finally got to hold him and this continued until he was discharged in May. So he was in from March through to May and I was working full-time and seeing my baby son in between times. It was a time I got through and being only 23 years of age you had to develop the stamina.⁴³

⁴¹ “Jackie,” interview with author, January 31, 2011.

⁴² “Wanda,” interview with author, January 8, 2011.

⁴³ “Shelley,” interview with author, January 10, 2011.

Feminism in Nursing

Although stamina was a desirable quality in a working nurse, the choice to work for pay was, in the 1960s and early 1970s, still perceived as an option for most middle-class women. The feminist call to the right to work but only for equal pay for women, was, for many working-class women, not an option. Increasingly, as the cost of living and the divorce rate rose, many women did not have the choice *not* to work. In that case, the question of whether to leave their children in daycare and whether to work full- or part-time was moot. Bev, a graduate of the Calgary General in 1965, had left nursing school, but after her marriage ended she returned to complete courses that she needed to graduate. Then she started full-time work to support herself and her daughter:

Bill and I separated [and] I moved to Calgary in October '67. And we probably separated in '66. So then I was a single parent, and thank God I had a full-time job. Because I was able to support us. So I had decided by then that I would try and get a job in Calgary. So I'd come back to Calgary and my biggest obstacle was trying to find a place to live.⁴⁴

While nurses were mandated to care for others, many also found the stamina required to perform their job was not something they could be proud of, and some became intolerant of the conditions that made such extreme stamina a basic requirement of employment. As Damien Brennan explains, for the first half of the twentieth century being a “good” nurse meant putting nursing above all else. As more married women with children entered the paid labour force, the demands of marriage and motherhood competed with the demands of this ethic of care at any personal cost. For some women in nursing, the rhetoric of the feminist movement addressed this tension and gave voice to their frustration over wages and working conditions. For other women in nursing, the feminist movement added to the feeling that the work of nursing was not valued in

⁴⁴ “Bev,” interview with author, January 10, 2011.

society.

Related to nursing's ethic of care and the lack of society's valuing of that care, David Coburn explains that "most of the 'subordinate' occupations in the health field are predominantly female. This may be viewed historically as the development of a complex health-care division of labour at a time when males were more dominant than they are now. Many female health occupations were 'born' under the control of medical men at a time when women were 'naturally' subordinate to men and when women were seen as particularly suited 'by nature' to what was viewed as the less complex tasks of caring."⁴⁵

While it is compelling to draw parallels between gender, women's oppression, and nursing, Florence Melchior warns we must be wary of assuming that every issue, tension, and debate in nursing and in nursing history can be explained through the lens of gender oppression. Melchior argues that "single theory explanations in nursing, such as subordination defined by gender, are not sufficient to explain the nursing experience. Nursing history, similar to women's history, requires many approaches and even several feminist approaches to facilitate an understanding of nursing's historical and present position in health care and society."⁴⁶ In nursing, as in the broader society, lines of oppression are not always clearly delineated, and as I have argued above, gender is but one axis of identity. Race, class, culture, and religion intersect to produce multiple and shifting subjectivities and experiences.

As Joan Sangster has argued, "Foucault saw power as productive, not repressive, moving 'from bottom to top as well as top to bottom in socio-economic hierarchies of

⁴⁵ David Coburn, "Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective," *Labour / Le Travail* 34 (1994): 143.

⁴⁶ Florence Melchior, "Feminist Approaches to Nursing History," *Western Journal of Nursing Research* 26, no. 3 (2004): 341.

society', dispersed, localized, 'never in anyone's hands.'"⁴⁷ In nursing, for example, not every doctor/nurse relationship was problematic, and, from a liberal feminist perspective, not every nurse felt oppressed by (male) doctors because they took orders from them, or because they earned a fraction of their income. For some liberal feminists, the right to work alongside male colleagues, albeit within a gendered hierarchy that was perhaps not always overtly apparent, provided an image of professional and social equality not enjoyed by the majority of working or middle-class women. As Julie Fairman has written, "As most nurses and physicians might argue, and as historians point out, relationships at the 'clinical moment' are much more complicated than simple exclusionist and victimization narratives suggest. Many clinical relationships are saturated with close, respectful, and collaborative experiences."⁴⁸ Nurses gained power through their association with medicine, and nurses were essential for the smooth functioning of the hospital system in which the authority of the physician dominated. For Val, a graduate of UBC in 1967, doctors were "gods," but they weren't necessarily bad gods:

We did a tremendous amount of stuff then, that a lot of people didn't always give you credit for. Although I got lots of credit, I thought, from the interns and residents, for making good decisions ... well, that played out really well with the interns who often, especially at the beginning of their internship ... and they didn't know anything, so I could just tell them what to do and what to order. They didn't know. I sort of laughed about it. I said, 'Here am I, telling the doctor what orders to write down.' He writes it all down and gets credit for writing the order, though I'm the one that told him what to write ... Interns and medical students are kind of a noxious miasma in the hospital, especially when they first arrive, because they're kind of dangerous. They don't know much, right? Don't know much. They're like a virus to have around ... I don't think there were any

⁴⁷ Joan Sangster, "Radical Ruptures: Feminism, Labor, and the Left in the Long Sixties in Canada." *American Review of Canadian Studies* 40, no. 1 (2010): 9.

⁴⁸ Julie Fairman, "Not All Nurses Are Good, Not All Doctors Are Bad," *Bulletin of the History of Medicine* 78, no. 2 (2004): 452.

downsides with that relationship at all. I had a very good rapport with them.⁴⁹

Some of the women interviewed were aware of the feminist critique of nursing as a so-called subservient profession and felt that it was their duty to speak against this criticism. Cora, a graduate of UBC in 1971, told me about her relationship to feminism in the early 1970s:

C: It's actually been good. I still, in the '70s, especially, when the so-called women's lib thing was going on, and I did consider myself a feminist for sure. I remember being at some meeting and some of these women were saying, well, 'Why would you be a nurse when you could be a doctor?' And I just thought, okay, because it's been traditionally a women's profession as being downplayed as something important. And I did speak up. I did say, 'Nursing is just as important as medicine.'

MS: And what do you think—what kind of reaction did you get when you spoke up like that?

C: Well, I think it surprised them. I don't think they expected to hear that. So I was glad I did.

MS: And if you were talking about that, what would you say to feminists in response? What would be your response ... that nursing is not a downtrodden female profession?

C: 'I am a feminist ... and I am a nurse.'⁵⁰

From a second-wave liberal feminist perspective, for Cora, the right of female nurses to work alongside male doctors may have represented, at that time, a form of gender equality in the workplace. Analysis of this opportunity at the level of wages, working conditions, benefits or professional autonomy, may not have been the most important axis of comparison between the two positions. For another woman interviewed, however, nursing *was* a symbol of the limited choices available in these decades. Vera, also a graduate of UBC a decade earlier than Cora, remembers that the feminist

⁴⁹ "Val," interview with author, January 19, 2011.

⁵⁰ "Cora," interview with author, February 18, 2011.

movement gave her a way to understand her personal dissatisfaction with the choices available to her when she chose nursing:

V: I'm not sure if it was the feminist movement, but our class in nursing was pretty radical in a sense that we didn't want to have a capping ceremony. We didn't want to do the oath. We were just a little bit radical, so I don't know if that came from the feminist [movement]. I wouldn't have described it that way, but there was a sense that women could do different things and that we didn't have to—we were quite irate when we had to stand up when doctors walked into the clinic area, or whatever. As a group we were, we were aware of that and there was—I don't know if it was just the influence of the university, or if it was more—I think we were just starting to think that way as a group, and we supported each other in that.

MS: Do you think, again, I'm just coming back to—would you have any thoughts on how the university setting might have influenced that particular kind of radicalism versus the diploma [programs]? Do you see any contextual influences there?

V: Oh, definitely. I think the university promoted thinking and acting and it was a time of change, I think, in those years. And I had friends in education and some of my classmates actually quit nursing and went into medicine and there were other options for women and I think we were starting to recognize them. And I think if I had been aware of it more, I probably would not have been a nurse.⁵¹

In contrast, for other women, to be a nurse was an indication of the strength and resilience of women, their ability to withstand and deal with the gendered order of things. The omnipresent assumption that a woman would rarely 'rise' to the level of a physician, or even want to be, or be able to take on the regular duties of a physician, meant that many women assumed that it was within their nature, and in fact the expected price of claiming waged status as a woman, to withstand adversity. Gail, a graduate of the Vancouver General Hospital School of Nursing in 1972, tolerated what she could not change:

MS: Would you say there was any kind of, when you think about that time, let's say the '70s, would you say there was any conflict between being a nurse and

⁵¹ "Vera," interview with author, January 31 2011.

being a feminist, for example? Were you conscious of any evaluations of nursing as a female ghetto or those sorts of things?

G: Not really, but I think nurses are basically pretty strong people. And even if there was that sort of maybe a little bit of abuse of power with the doctor-nurse, more of a male-female thing, where you have the men in charge and the women running around in circles.⁵²

For Beth, a graduate of UBC in 1967, feminism was not something that overly concerned her. She was aware of women's oppression, and of the nurse's oppression by doctors, but this awareness was beyond her everyday concerns as a wife and mother. Beth enjoyed nursing and found meaning in her work, which provided her with an income and a means to make a difference to people in need of her care:

B: I wasn't a wild and woolly feminist. You can tell, I mean, I got married, I had children, I stayed home. But I certainly have strong feelings about how women's lives go.

MS: Do you think feminism had any influence on nursing in the 1960s and '70s that you were aware of?

B: Not that I observed. Because I really think that we were stuck. We were stuck in a patriarchy model.

MS: And there wasn't the room then, and interest in feminism?

B: Well, that's what I'm wondering, whether people that went into nursing maybe didn't have that agenda quite so much. And you'd think they would. You have to be—the word that comes to mind is *ballsy*—to be a nurse. I mean, you can't just be a shrinking violet. I know when I considered what were the three options in my day, which was teacher, secretary, or nurse, there was no doubt in my mind that nurse was the one that had the most 'oomph' to it.

MS: Did you think so?

B: Well, I think there was some truth to it. Because we touched on that earlier, about nurses being the handmaidens for the doctors. There was truth in that. But for me, nursing was very fulfilling. Just, just knowing that you'd made the patient comfortable, or that you'd made a difference in their day, or whatever, gives you

⁵² "Gail," interview with author, January 31, 2011.

quite a bit of satisfaction. You don't even need any words or anything, you just kind of know that you've done your work.⁵³

While you might have had to be *ballsy* to be a nurse, that didn't necessarily include the feminist rhetoric of demanding fair wages and working conditions. Feminist ideals were only peripherally relevant for Mary, a graduate of St. Paul's in 1967, for Sara, a graduate of the Vancouver General in 1966, and for Maria, a graduate of the Calgary General in 1962. Mary remembers that she knew what feminists stood for, what feminism meant for nurses, and that she didn't personally know any:

M: Because I don't think the women's movement really hit Canada—well, you'd know better than me, but—I certainly wasn't involved with it.

MS: Tell me, just before we go into the demographic questionnaire, so I don't miss that piece, how is that? What makes you think that it didn't hit here?

M: I never had any contact with any woman, between 1960 and 1975, I never had any contact with any woman who was what you'd call a feminist, that I was aware of.

MS: Okay, what would you call a feminist?

M: Someone who was willing to stand up and say: Things aren't right for women. We need to change things. We need to, yeah, that's mostly it. And women need to feel stronger about themselves.⁵⁴

For many of the women interviewed, the feminist movement, in whatever form it was expressed was not something that they either took up personally as representing their own interests as women, or professionally, as representing or being a useful tool for nurses. It was only perhaps later, as the 1970s and a more vocal feminist movement took hold, that some nurses used the then popular rhetoric of second-wave feminist to take up a more vocal stand against unfair wages and working conditions, for example demanding the option for part-time work, maternity benefits and regularized shifts. Meanwhile, Sara

⁵³ “Beth,” interview with author, February 1, 2011.

⁵⁴ “Mary,” interview with author, January 12, 2011.

recalls that in the midst of being a wife, mother, and worker, she hadn't thought too much about feminism and nursing:

MS: I really was interested in your commentary about the influence of the feminist movement and that sounds like you didn't necessarily feel that there was that.

S: You know, I was so involved with family and kids that it kind of went over my head. Possibly I received benefits of it without realizing it, you know. But it wasn't foremost in my mind, or needed it to be, you know.⁵⁵

For Maria, the topic of feminism elicited a clipped response:

MS: Was [feminism] something that you were aware of?

M: Not very much aware of [it] at all.⁵⁶

Gradually, both liberal and labour feminist influences gained expression as nurses began to demand recognition as professionals, not "just" female professionals. Joan, a graduate of the Vancouver General in 1971 remembers:

MS: Were you aware of the, any sort of feminist influences on nursing at that time?

J: No, really. No ... I don't know if feminism really had much to do with how we nursed. I mean, I believe strongly in a woman having a choice in anything she does. I mean, nursing is nursing, if it's done by a male or a female. I didn't, [do the] feminist part, I don't know. Shortly after we graduated we got rid of our caps. We said that we didn't see the point of that. That was a bit of a rebellion on our part, on the way the nurses have changed their uniforms. I guess that was again some sort of rebellion against whoever decided that a nurse had to wear white and be starched and this and that.⁵⁷

Dawn, a graduate of UBC in 1976, remembers similar acts of rebellion:

MS: Can you tell me a little bit about how you see nursing influenced by feminism, or that civil rights movement at that time? Do you see, looking back, do you see there were any influences on nursing at that time?

⁵⁵ "Sara," interview with author, January 13th, 2011.

⁵⁶ "Maria," interview with author, January 7, 2011.

⁵⁷ "Joan," interview with author, January 25, 2011.

D: Okay ... probably influencing, oh, yes, influenced the relationships with the physicians, absolutely. Because I think those hierarchical barriers were beginning to be broken down at that time. So, and the symbols—so the symbols, the clothing, the caps, when I graduated from nursing, I washed my car with my nursing cap and I thought I'm never putting that baby on again.⁵⁸

Rather than being a sign of subservience and lack of choice for women, nursing provided one woman interviewed with a chance to carry on the tradition of independence set by her own mother's example. Dina, a graduate of the Calgary General in 1965, remembers that her mother was unusual in that she worked outside the home. Dina was inspired by her mother's independent spirit:

MS: Do you see any influence of the feminist movement in any of these events or attitudes?

D: Meaning? Well, I was always confident myself. I was young. That was, of course, to my advantage, as well. I thought I could do anything, Margaret ... Of course, feminism was going along, but again, my mother used to say, 'What is this feminist movement? I've always been empowered.' And she always was. And so it wasn't a matter of the time has come. I mean, when my mom was twenty-six, she was living in Saskatoon and she was manager of Simpson Sears, I wouldn't say outlet, but something like that. And that was considered very unusual for that time, because they always gave men manager things. And my mom never even batted an eye. Of course she was the manager, you see. So, part of it was the role modeling I had.⁵⁹

In addition to the example Dina received from her mother, the gendered hierarchy of the nurse/doctor relationship reflected broader realities for most working- and middle-class women in that their choices, both at home and in the workplace, were circumscribed by gender; for many, to differing degrees, gender intersected with race, class, culture, and religion to produce a constellation of powerfully oppressive discourses.

Women in nursing could choose a variety of responses to the sometimes oppressive conditions of their employment, and they may or may not have seen feminism

⁵⁸ "Dawn," interview with author, January 27, 2011.

⁵⁹ "Dina," interview with author, January 18 2011.

as a useful political tool to inform those responses. Resistance to the use of feminism as a political tool, is associated, according to Deborah Kane and Barbara Thomas with “the belief that political activity is unprofessional and unfeminine also has served to hamper nurses’ political awareness and participation in feminist-based political activism. Until we acknowledge linkages between these professional issues and feminism, we are abdicating our role in producing change in the status quo.”⁶⁰ A quote from my conversation with Rona, a graduate of the Royal Columbian Hospital in 1965, suggests how, in the everyday reality of nursing work, women positioned themselves in relation to feminist theorizing about nursing:

MS: What was your experience of the feminist view of nursing at that time? Or were you aware of it or even reflecting on it? What do you think?

R: Oh, yeah, well, it definitely was not a team. We had to do what the doctors told us to do. Even we were subservient to—as students—to anyone who was six months ahead of us. So you—on the elevator, if the elevator door opened you had to get off if there were people that were more senior to you, which were student nurses, or graduate nurses, or doctors. You had to get off. But then get back on again and again. In the chart rooms, if you were sitting charting, and somebody more senior came, you had to get up and give them your seat. I hated all that. I knew it was wrong. I knew that this shouldn’t be happening, but that’s what it was like and that’s what you did.

MS: Was there any protest? Did anybody have anything to say about it?

R: I don’t remember, during training. We just did it. We just did what we had to do. I certainly... as the years went by, I would be open about things. But I can’t quite remember when that started. But it always annoyed me that the nurses at coffee would sit and complain about things, but if there was a meeting and we had an opportunity to speak, nobody would speak. I often felt that I was the only one that would actually stand up and speak. And maybe that was more in later years, when we were unhappy about our workloads and things like that. But more and more—there was a time that people were really worried about their job and they thought that if they spoke out they would lose their job.⁶¹

⁶⁰ Deborah Kane and Barbara Thomas, “Nursing and the “F” Word.” *Nursing Forum* 35, no.2 (2000),19.

⁶¹ “Rona,” interview with author, January 25, 2011.

Summary

In this chapter I have argued that having made the choice to work, or having been compelled to work by necessity, most women had to tolerate the conditions their employment demanded, at a time when working conditions for many women reflected their low social status and the low value placed on their work. However, as established earlier in this chapter, nursing offered women a number of opportunities that were unavailable to the majority of other women, including guaranteed steady employment, a degree of social status, a degree of flexibility, an alternative or escape from marriage and motherhood, and/or a meaningful and fulfilling career. These opportunities came with a price, which included low wages; overwork; strict policies of dress and deportment; long shifts and split shifts; dangerous working conditions; sexual harassment and abuse; and lack of seniority, pension, and maternity benefits. Nurses who were interviewed about their attitudes toward feminism and nursing framed their responses primarily within the context of these direct workplace issues, rather than in relation to how the ideology of feminism as a broad social or political movement might have helped them theorize the systemic gender inequality that gave rise to these adverse or advantageous conditions.

From the range of responses to my questions about the influence of feminism, it is clear that these women had a variety of understandings of feminism. For some, feminism was a source of inspiration, for others, feminists were seen as condemning a profession that had deep personal meaning and practical application in their lives. Yet, others were indifferent or scornful of the influence of feminism on nursing, or its usefulness. The women interviewed also had different interpretations of feminism's usefulness in either theorizing about or changing their individual or collective ability to act against the

dominant gendered discourses that assailed them as they attempted to make their way in the paid labour market as married women with children.

Two significant directions for nursing emerged in these decades: unionism and a re-conceptualization of professionalism based on academic credentialing. As introduced in earlier chapters, the ideologies of labour feminism and second-wave liberal feminism, broadly represented the interests of working-class and middle-class women, respectively, and are used in Chapter Six to explain how these tensions, divisions, and areas of growth evolved. As women struggled to combine work, marriage, and motherhood, the advantages of unionization came to represent the strongest option to address workplace concerns. As other women in nursing capitalized on the career advantages of a university credential, a re-conceptualization of professionalism gained ascendancy over the traditional diploma/apprenticeship models. The next chapter presents these two overlapping but often competing discourses within the broader Canadian context and in reference to the experiences of women who struggled to confront gender discrimination and advance gender equality in the workplace and in society.

CHAPTER SIX

Paradoxical Relations of Power

MS: What attracted you to go back to school?

Jana: I had a boss from hell ... I thought, 'I'm going back to school... to hell with this!'

MS: Were there other reasons?

J: That was the main reason, but by then, the writing was on the wall ... if you wanted to have options, you needed the degree ... I loved bedside nursing, but I thought, well, if I go back to school, I will have some options ... I will be able to have some decision making power in my life and not have to put up with people like this – so I went back to get my degree because I really wanted to teach. We had positions in the hospital and I wanted to teach. I thought I would be good at that ... but when I finished, they had eliminated the teaching positions, but had added management positions. That's how I ended up in management. I thought 'what the hell, why not try this. Not only did I like it, I was good at it!'¹

Jana, graduate of the Calgary General Hospital School of Nursing, 1974

Leaders in nursing, who represented different and even competing interests within the profession, took up a number of seemingly divergent strategies to meet the needs of nurses for better wages and working conditions, accommodation in the workplace for caregiving roles, and the rising expectations of women for recognition of their skills, expertise, and education. Each of these dominant factions within nursing claimed to represent the interests of “the professional nurse.”

As Barbara Turkoski explains, throughout most of the history of nursing, a dominant paradigm of professionalism has prevailed. This paradigm has been “defined by predominantly male occupations that claim professional status and act to critique those occupations that aspire to professional status ... this male paradigm of professionalism is based on consistent and universal properties - isolated, free of context, with a neutral and

¹ “Jana,” interview with author, April 8th, 2011.

fixed meaning.”² This view of professionalism is consistent with a second-wave liberal feminist view of women’s gender equality according to Judith Wuest, which is also consistent with the aims of academically educated nursing leaders, rather than with front-line bedside nurses.³ According to Wuest, this patriarchal definition of professionalism, and the liberal feminist ideology to which it is linked, has implications for how nursing knowledge and practice is constructed and the criteria against which it is validated. As Wuest argues, in the 1960s:

Nursing theory has been developed by the elite and educated, the nurses who have wielded power in the development of nursing as a profession. The separation of these nurses from those at the bedside has been well documented. These nurses identified a professional route for the development of nursing knowledge and endorsed the patriarchal structure. Hence, the approaches to nursing theory reflect the dominant culture rather than the lived experience of nurses at the bedside.⁴

Nurses who chose to uphold a different definition of professionalism were not, however, without the support of feminist ideology. Within the second-wave feminist movement, the terms “worker” and “professional” implied hierarchical divisions within feminism, with the interests of “workers” being more representative of the labour feminist position, while the interests of the “professional” vested in the liberal feminist movement.⁵

The women interviewed might have responded to the idea that there were multiple or hierarchical interpretations of feminism with scepticism. In fact, none of the women interviewed identified themselves with any particular feminist ideology, nor were the

² Barbara Turkoski, “Professionalism as Ideology: A Socio-Historical Analysis of the Discourse of Professionalism in Nursing,” *Nursing Inquiry* 2, no. 2 (1995), 84.

³ Judith Wuest, “Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective,” *Journal of Professional Nursing* 10, no. 6 (1994): 357-367.

⁴ *Ibid.*, 363.

⁵ Eileen Boris, “Roundtable on Dorothy Sue Cobble’s *The Other Women’s Movement: Workplace Justice and Social Rights in Modern America*,” *Labor: Studies in Working-Class History of the Americas* 2, no. 4 (2005): 43–62.

terms “second-wave” or “labour feminism” ever mentioned. As is appropriate in an academic dissertation, however, in order to theorize about the women’s responses to questions about working conditions, marriage, motherhood, unions, and career opportunities, it is useful to draw upon the concepts of “labour feminism” and “second-wave (liberal) feminism” for their explanatory power.

Theorizing the Dialectic: Labour Feminism and Liberal Feminism

As presented in Chapter Two, Dorothy Sue Cobble describes the debate between labour feminism and liberal second-wave feminism as one expressing differing class interests. For Cobble, working-class women were more likely to promote accommodation for women’s domestic responsibilities in the workplace, while middle-class women tended to prioritize gender equality and equal access to male dominated systems of power.⁶ In this view, labour feminists were concerned mainly with the needs of working-class women, and they saw the labour movement as “the principle vehicle through which the lives of the majority of women could be bettered.”⁷ While working-class women may not have identified themselves as feminists, Cobble claims that feminist ideals were expressed in the leadership that drove the increasing involvement of women in unions. Conversely, as Annis May Timpson explains, “It was in the 1960s, once the second-wave of feminism took root in Canada, that women began to develop a sustained critique of the employment inequalities they experienced and [to] pressure their governments to address the problem through policy innovation and change.”⁸ According to this analysis, second-

⁶ Dorothy Sue Cobble, *The Other Women’s Movement: Workplace Justice and Social Rights in Modern America* (Princeton, NJ: Princeton University Press, 2004), 3.

⁷ Dorothy Sue Cobble, *The Other Women’s Movement: Workplace Justice and Social Rights in Modern America* (Princeton, NJ: Princeton University Press, 2004), 3.

⁸ Annis May Timpson, *Driven Apart: Women’s Employment Equality and Child Care in Canadian Public Policy* (Vancouver: UBC Press, 2001): 3.

wave feminists, specifically liberal second-wave feminists, sought not to accommodate gendered inequality, but to address the social conditions that gave rise to that inequality.

In reference to these differing perspectives within feminism, it is important to acknowledge the governing discourses of power circulating within feminist ideologies and to recognize how they are privileged differently within particular discursive contexts. Both labour feminism and liberal second-wave feminism represented the interests of powerful voices within the feminist movement, and within nursing. As Suzanne Gordon observes:

In the early twenty-first century, the arguments have barely changed, as those in the profession's elite continue to distance themselves from any association of nursing with 'second class,' working class work. Even though many groups who are considered to be professionals in the U.S.—from journalists, to actors, teachers and university professors, and even some doctors—have chosen to be union-represented, nurses seeking higher status and greater respect find it unsettling to be lumped together in a labor movement that includes janitors and construction workers.⁹

Employing the framework of labour feminism and liberal second-wave feminism, we can see that when diploma-educated, working-class nurses promoted the right of married women with children to earn a fair hourly wage while maintaining consideration for their primary roles as wives and mothers; their demands were consistent with the ideology of the labour feminist movement.¹⁰ Simultaneously, when mostly university-educated, middle-class nurses promoted an agenda of gender equality and the right of nursing to establish itself as an academic discipline on par with medicine, law, and engineering,¹¹ their objectives are more consistent with the aims of the second-wave

⁹ Suzanne Gordon, "Institutional Obstacles to RN Unionization: How 'Vote No' Thinking Is Deeply Embedded in the Nursing Profession," *Working USA* 12, no. 2 (2009): 284.

¹⁰ Cobble, *The Other Women's Movement*.

¹¹ Patricia D'Antonio, "Women, Nursing, and Baccalaureate Education in 20th Century America," *Journal of Nursing Scholarship* 36, no. 4 (2004): 379–384.

liberal feminist movement. These are, of course, generalizations, and there are varied perspectives on these divisions in the interviews. In fact, the demands of motherhood were a concern for both diploma- and university-educated nurses. Twenty-eight of the thirty-seven women interviewed graduated from the diploma-based programs and worked front-line nursing jobs. Of these, twenty-five became mothers. Nine of the women interviewed came from the UBC university program. Some of them worked in front-line nursing, but more worked in management, supervisory, and teaching positions either right out of graduation or soon after. Of these nine, six became mothers (see Appendix A: Table of Participants).

Uniting over Unionization

Just as motherhood was a concern for both diploma- and degree-educated nurses, so, too, were concerns about wages and working conditions shared between both groups, and concern for the image of nursing as a female profession, with its traditions and shared social memory, was not strictly limited to either university-educated or diploma-educated nurses. Issues such as wages and working conditions, and the status of nursing, affected the working nurse whether she had a diploma or a university degree; what differentiated these groups of nurses was their approach to the issues. What began in the 1960s as differing approaches to addressing common problems for women in nursing, widened in the 1970s into a rift within the profession, which, as Mark Roth and John Cutcliffe have argued, reverberates today.¹²

¹² Mark Roth, "The Gendered Workings of Class in Postindustrial, Service Sector Capitalism: The Emergence and Evolution of the British Columbia Nurses Union, 1976–1992" (Master's Thesis Simon Fraser University, 2008); John R. Cutcliffe and Lynn Wieck, "Salvation Or Damnation: Deconstructing Nursing's Aspirations to Professional Status," *Journal of Nursing Management* 16, no. 5 (2008): 499–507.

Membership did have its privileges, however. For the women who chose to, or had to, work in nursing at a time when opportunities for advancement into managerial or supervisory positions were narrowing, the profession's poor wages and working conditions, along with its lack of accommodation for working women with children, did not seem to be changing very quickly. The rise of the union movement in Canada in the 1950s and 1960s provided opportunities, support, and strategies for nurses who were concerned about their lack of representation by their professional associations in relation to workplace conditions; unionization provided such support and opportunities for leadership.

Despite the opportunities for representation provided through union membership, nursing's traditions did not endorse unionization. Leaders in nursing's professional organizations expressed their concern about the direction of labour organizing in *The Canadian Nurse*. This national professional journal published an article in 1968 that attempted to grapple with the apparent conflict between labour organizing and the image of nursing's professionalism, which had been promoted as part of the drive to close the diploma programs and residential schools of nursing, and instead move to academic credentialing as the basis of nursing practice. The article in the *Canadian Nurse* restated the position of the national nursing association presented more than two decades earlier: "In 1944, the Canadian Nurses' Association affirmed in principle the concepts of collective bargaining for its members ... two years later, [the CNA] passed a resolution 'opposed to any nurse going on strike at any time for any cause.' This policy remains."¹³

The author of the 1968 article noted that the main argument for disallowing strike action was that such action was incompatible with nursing's version of professionalism,

¹³ *The Canadian Nurse*, July 1968, 29.

and that withdrawing services placed the emphasis on working conditions rather than on patient care. As Suzanne Gordon has argued, in relation to the past and to more recent events, “In nursing, labor organizing is vigorously opposed by ‘nurse leaders’ who prize ‘professionalism’ over collective bargaining—and continue to associate the latter with truck drivers and coal miners.”¹⁴ However, acknowledging the adverse working conditions of most front-line nurses, the author of *The Canadian Nurse* article added that the association was concerned that if working conditions did not “improve drastically for nurses in this country,” there would be a withdrawal of services due to the low number of women going into nursing. The author pointed to the drop in new nurses “from 1944 to 1968 (25% to 7.9%),” and also noted that if “the number of registered nurses not employed in nursing continues to rise, there just won’t be sufficient nurses to care for patients in the future.”¹⁵

Similarly, Suzanne Gordon has argued that it was not always, or only, the so-called self-serving desire for better wages and fair working conditions that motivated nurses to join and form unions. Some leaders in the unionization movement saw the union as the most effective way to champion better working conditions that would, in turn, allow nurses to provide better patient care. Gordon comments that, “Conservative definitions of altruism posit an inevitable conflict between one’s own need for decent wages and working conditions—making it impossible for nurses to assert that they, like other professionals, work for money and not love, and cannot deliver high-quality services if they are overworked and mistreated.”¹⁶ As Audrey, a graduate of the Holy Cross School of Nursing in 1964, remembered when I ask her about what difference the

¹⁴ Gordon, “Institutional Obstacles,” 280.

¹⁵ *The Canadian Nurse*, July 1968, 29.

¹⁶ Gordon, “Institutional Obstacles,” 295.

union made to her nursing:

A: I think it came in in the early '80s, I'm pretty sure. I think that the nurses just saw a need for better working conditions. We really were pushed around a lot in terms of our hours. We weren't being paid properly and I think there was a real need for it. And it did a good job for us. Now, there were times when, I mean, I'm not really a union person. And there were times I would get quite angry at what they were demanding ... On the whole, I think that they [the union] improved our lot.

MS: So, it was a positive.

A: Oh, yeah. Like, even the fact that you need at least, what is it, not twelve, sixteen hours between shifts at least. All those kind of things made our life easier.

MS: Do you think they improved the quality of care?

A: Yes, in a roundabout way. If you were working a night shift and had to go back for evenings, you'd be pretty darn tired and your patients could suffer for it. Yeah, I think it improved the quality.¹⁷

Although nurses may have seen the benefits of the labour movement and even considered the advantages and necessity of striking, concerns in the media about nurses striking were long-standing. Nurses should be caring for patients, not out on the street picketing was a popular view expressed in a column in the *Vancouver Sun* of 22 April 1947. In that column, Dean Cecil Swanson of Christ Church Cathedral addressed the friends and family of 86 graduates of the Vancouver General Hospital School of Nursing, who totalled more than 1,000 people, at St. Andrew's-Wesley Church in Vancouver. Dean Swanson exclaimed, "I am alarmed at the organization, the unionism, that is creeping into many professions ... I hope and pray that this profession [nurses] will not fall into this open and obvious snare."¹⁸ Twenty years later, a *Vancouver Sun* reporter, covering the annual Canadian Nurses' Association (CNA) meeting at the University of

¹⁷ "Audrey," interview with author, February 8, 2011.

¹⁸ *Vancouver Sun*, April 22, 1947.

Alberta in 1966, quoted Dr. Brian Williams, professor of business administration and commerce, on the topic of nurses and labour organizing. Dr. Williams is reported to have suggested that labour action and strikes were incompatible with the public's image of nursing. Williams warned the 1,500 attending nursing delegates at the national conference, that "immediate adoption of collective bargaining by nurses might lead to a work stoppage and loss of the strong public support now held by the profession ... in many cases employer negotiators are face with fixed budgets and their sources of funds are largely restricted to city, provincial and federal grants ... why call a strike or a work stoppage [he argued] against a hospital that does not have the power to give you what you are demanding?"¹⁹ Here, Williams warns nurses and the public that forming a nurses' union will not achieve their aims because the employer, against whom they might make demands for higher wages and better working conditions, does not have the power to negotiate such conditions of employment. Conversely, B.C. delegate, Evelyn Hood, then director of personnel services with the Registered Nurses' Association in British Columbia, the only province having a certified body to bargain for nurses in Canada, is reported to have replied to Dr. Williams, that "in British Columbia the hospitals sign contracts with the nurses and then go to the government and say they are obliged to pay for the benefits contained in the contract [because] B.C. is a 'more highly unionized province.'"²⁰ This, Hood advised, was a national trend in nursing labour organizing and one that hospital boards and government were going to have to address.

Chronic concerns about nursing shortages in the 1960s and early 1970s continued to fan the flame of unionism despite disapproval from the public and from nursing's elite.

¹⁹ *Vancouver Sun*, July 10, 1968.

²⁰ *Ibid.*

As Janet Ross-Kerr observes, “The growing assertiveness of nurses and their willingness to challenge employers over wages and working conditions appeared to parallel increased activity in the women’s movement in society generally.”²¹ According to Mark Roth, nursing’s success in bringing attention to workplace conditions was a significant result of some nurses’ ability to reframe their work as women’s labour.²² However, it was not until 1966 that the Registered Nurses Act was amended “to allow for the process of collective bargaining.”²³ As mentioned above, the Canadian Nurses Association also supported wage increases, but not unionism or strikes. As a result, front-line nurses began joining non-nursing labour unions because their professional organizations were not supporting the kind of labour action they felt necessary to meet their goals.²⁴

Nurses were uncomfortable with unionization and other forms of job action including strikes for a number of reasons. In addition to the public’s lack of familiarity with the image of striking women, striking nurses in particular represented a contradiction to the image of nurses as selfless servants of society. According to Mark Roth, professional organizations likewise discouraged collective bargaining and instead emphasized a professional identity based on “service, duty, and altruism.”²⁵ These traditions run deep in nursing. As Suzanne Gordon has argued, “In hospital-organizing drives, management typically tries to exploit traditional gender stereotypes and women’s socialization in passivity, while mobilizing conservative notions of altruism and service

²¹ Janet C. Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta, 1859 to 1996* (Edmonton: University of Alberta Press, 1998), 270.

²² Roth, “The Gendered Workings of Class.”

²³ Ross-Kerr, *Prepared to Care*, 270–271.

²⁴ Alice J. Baumgart, “The Conflicting Demands of Professionalism and Unionism,” *International Nursing Review* 30, no. 5 (1983); Ross-Kerr, *Prepared to Care*; Kathryn M. McPherson, *Bedside Matters: The Transformation of Canadian Nursing 1900–1990* (Toronto: Oxford University Press, 1996).

²⁵ Roth, “The Gendered Workings of Class,” 25.

to perpetuate the subordinate status of nursing.”²⁶ As Maria, a graduate of the Calgary General in 1962, recalls, traditions in nursing dictated that money was not the issue:

It was, it was really, and you know, the nurses ... they just went on their way and didn't really worry about wages because you weren't really there for money, you were there to serve the people, you know, and take care of them.²⁷

For other front-line nurses, regardless of their desire to serve and be seen as professionals, wages were a major bargaining issue, and union organizers targeted this concern. For Shelley, the wages and benefits that the union could gain through bargaining were essential to keeping her family financially solvent:

It was in the union contract that if you were working a permanent part-time job that you were allowed benefits. And that was really why I kept on all these years because I felt I had it pretty good. I was able to work part-time and have these benefits, which covered the whole family. My husband had no benefits so we were able still to take vacations and I was able to go to seminars and to keep up with the advancement in nursing.

After an initial strike [in 1973], our wages almost doubled, and we got all retroactive [pay]. I remember getting \$3000 or \$4000 retroactive pay up to when our contract had expired previously. And [so we were] ... able to buy some furniture and stuff like that. Then we had another strike in '78 and another one in '81, and at various times they were threatening to take our benefits away from part-time people but we fought for that and we were able to keep it, which was really a lifesaver.

My husband had a pension at the time, and it was not compulsory for us at the start of our employment, it was optional. Somewhere along the way it changed, and it wasn't optional anymore. So all of those years, because my husband had a pension up until 1988, I did not pay into it, but then his job changed and he lost his pension. I decided then to pick up the pension so I bought it all back from 1988 to 1966. I paid it all back and that was the best decision I made, because now we can retire and we can still survive.²⁸

²⁶ Gordon, “Institutional Obstacles,” 280.

²⁷ “Maria,” interview with author, January 7, 2011.

²⁸ “Shelley,” interview with author, January 10, 2011.

Wages were also important to Maria, who recalls that after the formation of the Alberta Nurses Union in 1977, the head nurse on her unit brought in the union.

Previously, Maria's fifteen-year-old daughter had been working at Safeway and making three dollars an hour more than her mother:

Well, I thought they [the union] could really have improved [our wages]. My daughter, at the age of 15, started working at Safeway, and she made \$3/hour more than I did. And she worked just a few hours, a couple of hours after school and on Saturdays ... then ... the union was formed. And after that, then we went into that whole thing of negotiating and all that, and then our wages came up dramatic ... I'd say around '78.²⁹

It was not only married women with children who were concerned about wages and working conditions, and who benefited from union organizing. Pauline, a graduate of the Calgary General in 1965, had a career in public health. As a single woman she was able to live thriftily on her wages, but she still objected to the low wages for nurses and attributed it to gender discrimination. Teachers made more because often they were men who were expected to support a family, she explained. Pauline remembers that she and her fellow workers supported the union and went on strike for better wages and for working conditions:

When I came back and I worked in Calgary for two years for—I'm sure it was called the Department of Health, but it was Public Health ... we were actually on strike during that time. I'm sure it was wages, yes ... then I started nursing training, we actually worked a 44-hour week, and that was a bit of a political action, I think, during our first—maybe our second—year, that we went to a 40-hour week ... I think [in] '63. So that was a bit of a ... that was definitely a political situation. Because actually, some nurses, I don't know if they got suspended over it or just students, yet. Yes, it was things going on. Being on strike when I worked at the City of Calgary was an interesting experience. I forget how long we were on strike—ten days, maybe. Walking the picket line on 8th Avenue.³⁰

Benefits related to maternity and childcare were also an issue and improved as a

²⁹ "Maria," interview with author, January 7, 2011.

³⁰ "Pauline," interview with author, January 17, 2011.

result of union involvement. Corrine, a graduate of St. Paul's Hospital School of Nursing in 1965, remembers that nurses benefited from the labour movements of the 1960s and 1970s:

There was no union when ... I had to quit when I was pregnant. There was no maternity leave. You lost your seniority. And that was it, you know. So there were no perks, so to speak, when it comes to nursing, right? So, I'm sure the union made a huge difference, when nursing unionized.³¹

Deeper Divisions: Voices of Dissent

While not an absolute rule, the work of front-line nurses to unionize can be understood within the framework of the labour feminist ideology of workplace accommodation for women's domestic caregiving roles. As Florence Melchior and Kathryn McPherson explain, nurses' efforts to promote the interests of working married women in the 1960s and 1970s contributed to a changing conceptualization of the place of middle-class women in Canadian society, but, as in the broader society, there were divisions among women on this topic.³² In this regard, Melchior claims that "proper roles for Canadian women in the 1970s included the right to form unions and strike for better pay and work benefits—something that nurses successfully did do."³³ However, Melchior warns that, "as rank-and-file nurses became more vocal through unions, the division between them and nursing leaders who aspired to professional status for nurses became deeper."³⁴

The emerging power of unions and the emerging power of academia were facilitated in part through the rhetorical power of various streams of the feminist

³¹ "Corrine," interview with author, January 7, 2011.

³² Florence Melchior, "Feminist Approaches to Nursing History," *Western Journal of Nursing Research* 26, no. 3 (2004):340-55; McPherson, *Bedside Matters*.

³³ Melchior, "Feminist Approaches to Nursing History," 345.

³⁴ *Ibid.*, 344–345.

movement, which promoted public awareness of gender inequality. However, as William Carroll and Rennie Warburton explain, in the 1960s and 1970s “the anti-unionism found in the surrounding political culture probably deterred many nurses, and particularly those strongly committed to ‘professional’ service, from seeing themselves as typical unionized workers.”³⁵ Despite our ability to theorize about various feminist positions and nurses’ potential allegiance to them, for the women interviewed, the question of professionalization was never mentioned; all would call themselves professional nurses, whether they graduated with a diploma or a degree. What the diploma graduates *did* question was the right of the university graduates to take their professional identity away from them. Diploma-based nurses’ resentment of the university students and graduates, found in the interviews, in retrospect, highlights class and increasingly racial divisions and tensions within the profession. Using the lens of liberal and labour feminism, these divisions and tensions were primarily seated in competing definitions of professionalism and the emergence of unionization. As Mary, a graduate of St. Paul’s School of Nursing in 1967, told me:

M: Here’s my bias—I personally don’t think that nurses who receive nursing education through a university get enough grounding in clinical skills. They learn a lot about critical thinking, but I don’t think that it carries through all the time.

MS: To the skills part, you mean.

M: Right. And I know you went to UBC.

MS: Yes, that’s right, I did.

M: And actually, once I was in—or out—of nursing school, I truly did not meet a UBC grad that I would ever take as a role model.³⁶

³⁴ William K. Carroll and Rennie Warburton, “Feminism, Class Consciousness and Household-Work Linkages among Registered Nurses in Victoria,” *Labour / Le Travail* 24 (1989): 144.

³⁶ “Mary,” interview with author, January 12, 2011.

For nurses such as Mary, the ascendancy of academia created a division between herself and her nursing colleagues in which her own knowledge and sense of professionalism was challenged. Since the 1960s, as Wuest explains, this challenge persists because, “In the health care field, patriarchal standards have reigned and the personal experience of professional caregiving has been devalued.”³⁷

Dual, But Not Necessarily Duelling

Unionization and professionalization are but two frameworks for presenting a very complex set of developments. As Carroll and Warburton contend, professionalism and unionism were not always at odds.³⁸ Whether nurses held a diploma or a degree, they were the most highly educated and highly paid professional women in the public service. Many of them, Carroll and Warburton explain, were “committed to careerist progression up a ladder of achievement, prestige and authority ... many ... [were] torn between allegiances to management and commitment to their nursing sisters and other workers.”³⁹ Increasingly, opportunities for advancement up that ladder depended on a university degree. According to Mark Risjord, the rising power of academia, and nursing’s bid to expand its stake in academia, privileged the status of a university nursing education to the detriment of acknowledging the value of the skills and knowledge base of the diploma-educated nurse.⁴⁰ The result was that members of the nursing elite were working hard to strategically establish nursing as an academic discipline, rather than as a form of well-paid working-class women’s labour. I would argue that they achieved this goal, not as a

³⁷ Judith Wuest, “Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective,” *Journal of Professional Nursing* 10, no. 6 (1994): 364.

³⁸ Carroll and Warburton, “Feminism, Class Consciousness and Household-Work Linkages.”

³⁹ *Ibid.*, 144.

⁴⁰ Mark W. Risjord, *Nursing Knowledge: Science, Practice, and Philosophy* (Ames, IA: Wiley-Blackwell, 2010): 66–75.

result of moving nursing into academia, but, rather, as a result of the increasing status of university education, and women's greater access to that education. Thus, nursing, once seen as a respectable and suitable occupation for mainly working-class women, was more and more seen as a potential vehicle of upward social mobility for both working-class and middle-class young women. Nursing leaders seized this opportunity to promote a new image of the professional nurse based in the midst of the more middle-class prestige of the university campus.

At the same time that nursing was moving more solidly into the academy, greater numbers women were entering university programs generally. For Kelly, who came from a wealthy Vancouver family and who graduated from the UBC School of Nursing in 1967, entry to a professional program afforded the family status, even if it was a nursing program. Young women, according to Kelly, saw advantages to attending a university program:

Yeah, if you grew up in West Vancouver, there wasn't a better place to tell people you were going to than UBC. People, oh, you're going there. You know, like, I grew up—my school was very academic. It still is a very academic school, that West Van High. And a lot of people, that was sort of—they saw that as a place to go to connect with people. And the joke was, 'I'm looking for an MRS, what are you looking for?' And there were lots of serious-minded women out there who had a career focus and they were doing this and that, was what they were doing. And there were men and women—more men than women—and that was another reason that women liked it. There were more men . . . When I went to university, there were way more men than women. I'm sure that had something to do with it.⁴¹

The drive to re-conceptualize professionalism within an academic credentialing framework, had support from powerful nursing leaders, and the progressive version of nursing education is now the official version that documents the advancement of nursing,

⁴¹ "Kelly," interview with author, January 28, 2011.

sanctioned by numerous government-funded reports. For example, in a 2004 report titled *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada*, which was partially funded by the Government of Canada and conducted by the Nursing Sector Study Corporation, a subsection titled *Nursing Education in Canada: Historical Review and Current Capacity* sought to put certain aspects of developments in nursing and nursing education into perspective.⁴² The authors outline two important events in the twentieth century. The first was the “struggle” to “wrest” control of nursing education from hospitals. The second was the task of “determining the structure of a nursing baccalaureate degree program.”⁴³ The authors identify three major studies that affirmed the view that hospital-based nursing education was inferior to a university-based education: the first, a report commissioned by the Government of Canada and produced by George Weir, professor of education at UBC in 1932, and next, two reports by Dr. Helen Mussallem from 1960 and 1965. In the 1965 report, written for the Royal Commission on Health Services, “Mussallem recommended that all nursing education come under the control of educational institutions and that they prepare two categories of practitioners: the technical nurse and the professional nurse. The professional nurse was to be educated in a university and the technical nurse in a two-year program under the auspices of universities.”⁴⁴

When I asked Shirley, a graduate of the Vancouver General Hospital School of Nursing in 1967, what she thought of the demise of the on-site hospital-based programs and the rise of university degree programs, she had a number of interesting things to say

⁴² Dorothy Pringle, Linda Green, and Stacey Johnson, *Nursing Education in Canada: Historical Review and Current Capacity* (Ottawa: Nursing Study Sector Corporation, 2004).

⁴³ *Ibid.*, 16.

⁴⁴ *Ibid.*, 17.

about the ‘new’ professionalism in nursing:

S: The only thing, I would like to say, that the training that was on site was ... I felt that some of the old-style nursing worked very well in many situations, rather than the remoteness I had felt in the experience of being a patient, the times I’ve had to be a patient.

MS: When you say ‘old style,’ can you tell me a bit more about that?

S: Well, if somebody went into a room at that time, and you saw that there was a dirty bedpan around, or something was amiss, or whatever ... you’d look after it, make sure it was tidy. Now you’d have to wait for somebody, you know, the floor cleaner, or somebody else on a lower level. You know, they wouldn’t pick up anything off the floor. It just, it’s sort of like they’ve become above doing the job that needs to be done, to make sure that things work well.

MS: How has that come about? What do you think’s made that change?

S: Well, there’s a lot of people that want to—I mean, you can be professionalized and still be able to do some of the things that need to be done without sort of saying ‘it’s not my job.’ I think a person that truly is a professional can cross those borders occasionally. And it’s when the borders were so defined that I think they lost out.⁴⁵

Shelley, a graduate of the Calgary General in 1966, told me that her three-year degree program prepared her to become the professional she expected to be:

Well, as I graduated in the early ’70s and late ’60s, working on the units, we were expected to act very professionally. Ethics was very much a part of my nursing. We had to follow what was expected of us. Any senior staff, we had to use proper names, never first names. It was very important to respect our clients’ privacy, which it still is today. And always keep confidences in confidence and respect others. We had to even stand when some of the doctors walked in the room if we were at a meeting, just out of courtesy. So, all these protocols seemed to instill in us sort of an esteem for nursing. I feel, though, that there was a big change that came during the ’60s and ’70s during nursing.⁴⁶

The struggle for professionalism, or the status that the term implies, has been an elusive goal for nurses. As indicated in the interviews, both front-line nurses and those in

⁴⁵ “Shirley,” interview with author, January 7, 2011.

⁴⁶ “Shelley,” interview with author, January 10, 2011.

supervisory and leadership positions describe themselves as professional nurses. Florence Melchior explains that the growing gulf between the professional identities of these two groups led to a situation where, “as rank-and-file nurses became more vocal through unions, the division between them and nursing leaders who aspired to professional status for nurses became deeper.”⁴⁷

Damien Brennan argues, however, that shifting nursing education to the university setting has not necessarily changed the perception of nursing as a lower-status, gendered profession for women. He explains:

Nursing work became situated at the lower end of a hierarchy, within which status associated with nursing was primarily attached to the perceived virtues of duty and vocation, which became principle incentives for people to enter and remain in nursing. It will be suggested that such perceived virtues no longer accrue status within contemporary western society. This has led to an anxiety within nursing to endeavour to secure status primarily through assimilating to, and advocating, scientific rationale and professional recognition.⁴⁸

Challenging the Discourse

As was suggested above, the bid to claim disciplinary status meant the nursing elite was called upon to translate caring into something that could be measured using methods of scientific inquiry. In the present context, however, Damien Brennan wonders whether the relevant question is not “Is nursing a profession?” but, rather, “Should nursing *want* to be a profession?” Brennan explains that the definition of professionalism taken up by the nursing elite in the second half of the twentieth century is patterned on a definition of nursing that devalues traditions of caring. This definition, according to Brennan, includes “a claim over a monopoly of knowledge, a self-regulated and

⁴⁷ Melchior, “Feminist Approaches to Nursing History,” 344-345.

⁴⁸ Damien Brennan, “Commentary: The Social Construction of ‘Woman’s Work’: Nursing Labour and Status,” *Journal of Nursing Management* 13, no. 4 (2005): 282.

controlled registration of entry, a legally backed monopoly of practice and autonomy.”⁴⁹ Brennan claims that this standard, which privileges autonomy is not congruent with “the act of caring which lies at the core of nursing.”⁵⁰ He questions an ethic of professionalism that claims “a monopoly of intellectual property over insights into birth, death, health and illness, which inform the knowledge base for caring.”⁵¹ Rather than enhancing patient care, Brennan wonders if this model merely serves the purpose of “establishing and reproducing power.”⁵² Brennan further argues that there has been criticism about this current definition of professionalism in nursing, with some theorists wondering whether “professionalism is a desirable and worthy model for nurses to pursue ... [or] just an advance into a cul de sac.”⁵³ Accordingly, the drive to embrace a standard of professionalism based on academic credentialing, which emphasizes scientific positivism as a model for knowledge development, and a standard of professional ethics that emphasizes autonomy, independence, and a clearly defined scope of practice, does not do justice to the traditions that have made nursing such an enduring and valuable social resource. He further argues that, “several strategies have been adopted by nurses in the pursuit of occupational status. Unfortunately, the popular contemporary strategy [academic professionalism] appears to be one which advocates an exit from nursing care.”⁵⁴ Similarly, Elizabeth Herdman argues:

Faith in progress is manifested in nursing historiography and contemporary nursing literature, in the basic tenet of nursing orthodoxy, that professionalization is both inevitable and desirable, in the alignment of nursing with medical science and technology and the belief that

⁴⁹ Ibid., 283–284.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid., 284.

Western nursing is the model for nursing world wide. It is argued that this uncritical faith in a continuously improving future has obscured nursing's vision for the future and rendered it powerless in the face of rapid global economic and social change.⁵⁵

Summary

In this chapter, I have suggested that divisions occurred within the profession as members vied for public recognition of the value of nursing because this bid took two dramatically different, although not always exclusionary paths: unionism and academic professionalization. Similarly, in the broader society, women struggled to gain recognition for their contribution to society as paid and unpaid caregivers. As Holmes and Gastaldo have argued, "The governance of society occurs within a constant struggle of conflicting interests [and] as with any other exercise of power, dominant discourses in nursing face resistance."⁵⁶ Feminism gave nurses and nursing leaders the language to articulate that resistance and make what Christine Ceci describes as "a credible claim to know."⁵⁷ And yet, it appears that then, as now, the ascension of nursing into the upper tiers of social, economic, and political influence has been blocked. This is not because nurses were unable to articulate the truth about their value as essential workers, but rather, as Ceci explains, because it appears that the bid for professionalism based on the 'science' of caring has not gained the hoped for status that the 'science' of medicine has always held. Due to this privileging of medically based science, rather than caring based science, nursing has not gained a credible, or lasting, foothold that would give nursing

⁵⁵ Elizabeth Herdman, "The Illusion of Progress in Nursing," *Nursing Philosophy* 2, no. 1 (2001): 4.

⁵⁶ Dave Holmes and Denise Gastaldo, "Nursing as Means of Governmentality," *Journal of Advanced Nursing* 38, no.6 (2002): 560.

⁵⁷ Christine Ceci, "Nursing, Knowledge and Power: A Case Analysis," *Social Science & Medicine* 59, no. 9 (2004): 1879.

parity with the status of male-dominated professions. Ceci suggests that this is because nursing remains a female-dominated profession and because:

Knowing always involves social relations of power ... it is the politics of epistemic practices rather than something we might think of as 'knowledge itself' that governs such things as who speaks, who listens, who defers, and who is deferred to ... who can be and should be believed is then based not on what one could be said to know but on who one is.⁵⁸

⁵⁸ Ibid., 1882.

CHAPTER SEVEN

Discussion and Conclusions

Changes in women's relationship to caring labour, and changes in attitudes toward the role of nurses as paid caregivers, are revealed in thirty-seven oral history interviews with women who became nurses between 1958, a pivotal time in the development of the publicly funded health-care system, and 1977, when the last student from the schools in this study graduated from the Holy Cross Hospital School of Nursing in Calgary, Alberta.¹

In this dissertation I have argued that rather than being a site of gender oppression and unremunerated servitude, nursing education and nursing in these decades was a form of women's labour that exemplified employed women's struggles to obtain a useful and rewarding career. I suggest that nurses acted in multiple ways that have not been previously acknowledged to promote fairer wages, better working conditions, and access to the benefits of economic citizenship in Canada for all women. As the status of a university education rose in the 1960s, and the need for nurses expanded along with the growth of the publicly funded health-care system, leaders in nursing leveraged the demand for nurses, the demands of feminists for greater access to education and career opportunities for women, and the strength of the union movement to make the voice of nurses heard at multiple sites of social, economic, and political influence. Differing goals and strategies put forward by nursing leaders in this period caused polarization, which led to internal divisions along class lines and opposing conceptualizations of educational credentialing and professionalism. These divisions and their impact on nursing remain unresolved.

Class, as a major dividing influence within nursing, has not previously been explored

¹ "Holy Cross School Of Nursing (Calgary, Alberta)," description of the Holy Cross School of Nursing fonds. In University of Calgary Library Special Collections.

from the perspective of women who lived through these galvanizing decades. A more nuanced and complex account of their experiences inserts a particular angle of analysis into the current debate about nursing and professionalism. This analysis challenges the narrative of progress that has represented the stories of the closure of residential and hospital-based programs, and the interests of front-line diploma-educated nurses as a less sophisticated precursor to the current privileging of academic credentialing and its related governing discourses.

Main Arguments and Findings

Desiring Nursing: Hospital-Based Programs

In Chapter Four I argued that hospital-based nursing education was *not* a site of gendered oppression. Rather, I argue that, in significant ways, women enrolled in and graduating from nursing programs in the 1960s and early 1970s transcended gender and class limitations and achieved a unique and valuable credential unavailable to most other young women from similar class and cultural backgrounds. While young women enrolled in the hospital-based programs, including both residential and university programs, were subject to strict rules of social regulation, these rules and regulations were not unusual or more onerous than restrictions and expectations placed on other working- and middle-class young women in this period. In fact, for some young women, the regulations were less restrictive, and living conditions in residence provided a degree of luxury that they had not experienced at home. As Mona, a graduate of the Calgary General in 1967, remembers, nursing school was “heaven”:

Our rooms had a sink in it but not a bathroom Our rooms had a sink in it but not a bathroom. So the lid lifted up, the lid of our desk lifted up. There was a mirror underneath there and a sink. Yeah, so it was nice—or was the sink beside it, I’m trying to think now. I have kind of forgotten. But anyway, for me, I loved being in residence. It was the first time in my life I’d ever had a bed all to myself. It was the first time in my life I’d ever had a room all to myself, or a closet all to myself, or drawers all to myself. Because I always had to share everything—my sister and I slept in a bed from the time she left the crib, I guess. So from the time she was

probably two or three we slept together ... and so when I was going off to nursing my parents bought me a set of luggage and I packed my stuff and moved into residence and I just thought I'd died and gone to heaven ... I really liked it. Somehow you were grown up. You got to move out, you had your own room.²

Nursing: Working Motherhood

In Chapter Five I argued that hard work, whether paid or unpaid, was a common experience for most adult working- and middle-class women. What was *uncommon* was the desire to be a hard-working *paid* woman while also balancing the responsibilities of marriage and motherhood. The demand for nurses in the expanding, publicly funded health-care system meant that more nurses were continuing to nurse following marriage and motherhood; however, the primacy of women's domestic roles remained a strong influence and mitigated, for some women, the advantages offered in nursing in this period. While nursing offered many opportunities, there were as many challenges due to the lack of accommodation for working married women, particularly those with children. Feminism, in both its labour and liberal forms, provided a way for women to theorize gender oppression, and nurses took up this rhetoric to differing ends and in different ways, which contributed to a growing division within nursing based on class interests and career ambitions. For example, Maria, a graduate of the Calgary General in 1962, recalls that nursing gave her and her husband an opportunity to achieve their dreams in a way that other professions could not:

Actually, I hadn't planned—like I said, I was going to be a stewardess and that, and travel, but I ended up getting married instead. And to be honest, how it happened, I really don't know. It just did ... we worked out and we got our house and a car and everything worked fine ... My husband was a fire fighter so we both worked shift work, we both worked weekends, and that way we were able to care for our kids without having them sent to babysitters, or whatever.³

² "Mona," interview with author, January 18, 2011.

³ "Maria," interview with author, January 7, 2011.

At the same time, women who combined nursing with marriage and motherhood revealed that they did face gender discrimination, a common experience for women in the broader society. Jackie, a graduate of the Calgary General in 1964, recalls that the label “handmaiden” was not far off the mark in describing how relations between doctors and nurses translated into a familiar gendered dyad:

I think it was that you’re serving, it’s a service job ... you were never told you were a professional. You were in service to the patient, to the doctors especially. And of course at that point most of the doctors were men and we were to be their handmaidens, basically. You know, that’s somewhat where you go, really, because there were no male nurses ... the doctors really protected their ... their position and they really wanted to be catered to.⁴

And yet, the influence of both liberal and labour feminism made inroads and coloured assumptions about the primacy of the gender hierarchy in the hospital, and in eventually, in the home. When I asked Peggy if feminism influenced nursing, she replied:

Yes, I think it did. I think I really sort of started to challenge the subservient role of a nurse. You know, getting the charts for the doctors, standing up—we were still doing that at Children’s. Those kinds of behaviours, I started to think, ‘Well, wait a sec, I’m just as equal. They don’t stand up for me. So why do I stand up for them?’ And ‘get your own chart,’ kind of thing ... those things I started to question. ‘How can I get out of this?’ I’m not liking what ... and I started to read a whole bunch of feminist books at that time and get into this whole thing about equality, and so I left Children’s Hospital and got a job at UBC Psych. That was more of an independent kind of nurse role in terms of those traditional behaviours. We didn’t have to do any of that. We didn’t have to stand up for anybody and get charts and do all this, that. We had a lot of input in nursing care there. Nurses were real leaders up there.⁵

Unionization and Professionalization

In Chapter Six I argued that women working in nursing were poorly paid and worked under adverse conditions. Due to systemic gender discrimination and traditions in nursing that emphasized altruism and service, as well as an emerging discourse that privileged a university

⁴ “Jackie,” interview with author, January 31, 2011.

⁵ “Peggy,” interview with author, January 7, 2011.

degree over a college-based or residential diploma, front-line nurses, who were usually diploma-educated, appear to have favoured a labour feminist perspective, while university-educated nurses, who were often supervisory staff and educators, condemned labour organizing in favour of a discourse of academic credentialing which at this time, largely precluded unionization and labour action such as striking. As a result of these debates, tensions, and divisions, nursing education and practice came to be divided within a so-called hierarchical order, placing the skills and knowledge of bedside nursing in a more regressive position in relation to the knowledge generated by academic scholarship. Not so broadly discussed is the fact that, for other women and nurses, neither unions nor professionalization represented their aims, nor did they all agree they had achieved success in making their working lives better or raising their social profile. Interviews with women who were working mothers and wives in these decades unsettle assumptions about the gains made through the feminist movement as either union members or members of professional organizations. In order to create and re-create positions of power for themselves in the health-care system, nurses have always had to exercise political astuteness. Even to the present day, nurses have continually managed to shape and re-shape nursing to respond to the demands of the health-care system in a way that their services have remained essential to the smooth functioning of that system.

Significance of the Study

As we look back at these important decades, the significance of this study is its illumination of a history that tells us something new about how nurses navigated motherhood and the work world in various complex ways that have not received the kind of nuanced attention and interpretation they deserve. In this dissertation I have presented major events in nursing history in western Canada within the framework of liberal second-wave feminism, and labour feminism.

I have also examined the roles of nurses and the social expectations of that role using Foucault's conceptualization of governmentality in order to trace changes over time in the gendered distribution of power for working- and middle-class Canadian society. Findings from this study suggest that from a liberal feminist perspective, nursing can be viewed as either a gendered ghetto of female subservience, or, as the vanguard of challenging assumptions about women's changing social roles and their demands for the benefits to economic and social citizenship. This study challenges the view that nursing was a unified profession, uninfluenced by class, culture, or race. Instead, we come to see nursing as a complex mix of competing and complementary interests and strategies related to the broader struggle by women to improve wages and working conditions for working married women. In particular, nurses used the increasing status of being a professional woman with a post-secondary education as well as the rising power of the union movement, to raise the profile of those demands. The influence of a number of important feminist ideologies, most significantly liberal second-wave feminism and labour feminism have been suggested as providing a way to theorize the various positions and strategies employed by both diploma and university educated nurses to meet their overlapping and sometimes contradictory goals.

The stories of women who lived during this critical time in nursing and women's history reveal that, as powerful in numbers as nurses were, as essential as their services appeared, and as persuasive as the rhetoric of labour or liberal second-wave feminism was, what was more powerful were (and are) "gendered and gendering" discourses that positioned and position nurses as *not* credible "to know and do" what they feel they need to know and do to provide expert nursing care. This is due, in part, to the fact that nursing has been (and is) positioned within a set

of gendered discourses that define and privilege a kind of credibility that is “secured in the context of certain regulatory norms, images and ideals that tend to exclude women.”⁶

These stories also reveal that nurses have not been passive bystanders to their own oppression. Holmes and Gastaldo argue that nurses are also implicated in exclusionary gendered practices. They assert that “nurses constitute and make feasible the institutions and systems that they believe are the source of their oppression.”⁷ Thus, the experiences of women who became nurses in the 1960s and early 1970s serve neither to “prove” nor “disprove” the emancipation or oppression of women or nurses by “others” in this critical period of change. Instead, these experiences, analyzed through the lenses of feminism, governmentality, and feminist oral history, serve to complicate assumptions about the victories and defeats of women in nursing during this period. They also serve to challenge the narrative of progress that often goes unchallenged in the discussion of current issues and debates in nursing and nursing education.

As the stories of the women interview remind us, events and experiences are “not something good or bad but something that, on an ongoing basis, we must think about.”⁸ Women who were nurses in these decades had complex experiences and reactions to the gendered discourses in which they participated, challenged, changed, and resisted. The women interviewed did not reject their primary role as mothers and wives, nor did they resist the attractive promises of a career and increased family income. They neither won fair wages and better working conditions as working mothers, nor were they defeated and turned away from nursing. They were not won over by the rhetoric of the “new” professional nurse with her baccalaureate authority,

⁶ Christine Ceci, “Gender, Power, Nursing: A Case Analysis.” *Nursing Inquiry* 11 no.2 (2004), 79.

⁷ Dave Holmes and Denise Gastaldo. “Nursing as Means of Governmentality.” *Journal of Advanced Nursing* 38, no. 6 (2002): 558.

⁸ Ceci, “Nursing, Knowledge and Power,” 1888.

nor did they retreat with their diploma and bedpan to do the bidding of their more educated colleagues. As a whole, I argue that the contribution of this dissertation is not to take a particular stand or defend a particular interpretation of nursing history, but rather to illustrate the complexity of nursing's relationship with power and knowledge at a particular point in time and to show how these complex relationships continue to infect and inflect difficult divisions that characterize relationships between nurses within a workplace context where, for the benefit of those for whom nurses care, would be better minimized.

Bibliography

- Abrams, Lynn. *Oral History Theory*. Milton Park, Abingdon, Oxon ; New York, NY: Routledge, 2010.
- Adams, M. L. "In Sickness and in Health, State Formation, Moral Regulation, and Early VD Initiatives in Ontario." *Journal of Canadian Studies-Revue D Etudes Canadiennes* 28, no. 4 (1993): 117-30.
- Anthony, S. E. and J. Landeen. "Evolution of Canadian Nursing Curricula: A Critical Retrospective Analysis of Power and Caring." *International Journal of Nursing Education Scholarship* 6, no. 1 (2009): 1-14.
- Arnup, Katherine, Ruth Roach Pierson and Andrée Lévesque. *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*. New York: Routledge, 1990.
- Axelrod, Paul. "Historical Writing and Canadian Education from the 1970s to the 1990s." *History of Education Quarterly* 36, no. 1 (1996): 19-38.
- Baer, E. D. "'do Trained Nurses...Work for Love, Or do "they Work for Money?" Nursing and Altruism in the Twenty-First Century." *Nursing History Review* 17, (2009): 28-46.
- Barnes, Charles. "The Nature of Social Justice," in *Caring for the Vulnerable: Perspectives in Nursing Theory, Practice, and Research*, ed. Mary de Chesnay. Sudbury MA: Jones and Bartlett Publishers, 2005.
- Baron, Ava. *Work Engendered: Toward a New History of American Labor*. Ithaca: Cornell University Press, 1991.
- Bates, Christina. "Looking Closely: Material and Visual Approaches to the Nurse's Uniform." *Nursing History Review* 18, (2010): 167-88.
- Baumgart, A. J. "The Conflicting Demands of Professionalism and Unionism." *International Nursing Review* 30, no. 5 (1983): 150-55.
- . "Hospital Reform and Nursing Labor Market Trends in Canada." *Medical Care* 35, no. 10 Suppl (1997): OS124-OS131:124-31.
- Baumgart, A. J. and R. Kirkwood. "Social Reform Versus Education Reform: University Nursing Education in Canada, 1919-1960." *Journal of Advanced Nursing* 15, no. 5 (1990): 510-16.
- Belenky, Mary Field. *Women's Ways of Knowing: The Development of Self, Voice, and Mind*. New York: Basic Books, 1986.
- Bilge, Susan. "Recent Feminist Outlooks on Intersectionality." *Diogenes* 57, (2010): 58-72.

- Bliss, Michael. "Contrary History: Socialized Medicine and Canada's Decline." *CMAJ : Canadian Medical Association Journal = Journal De l'Association Medicale Canadienne* 177, no. 2 (2007): 224-24.
- Block Tina. "Families That Pray Together, Stay Together": Religion, Gender, and Family in Postwar Victoria, British Columbia." *BC Studies* no. 145 (2005): 31-54.
- Boris, Eileen. "Roundtable on Dorothy Sue Cobble's the Other Women's Movement : Workplace Justice and Social Rights in Modern America." *Labor: Studies in Working-Class History of the Americas* 2, no. 4 (2005): 43-62.
- Boris, Eileen and S. J. Kleinberg. "Mothers and Other Workers: (Re)Conceiving Labor, Maternalism, and the State." *Journal of Women's History* 15, no. 3 (2003): 90-117.
- Boris, Eileen and Joan Sangster. *The New Women's Labor History*. Durham, N.C: Duke University Press, 2006.
- Bothwell, Robert, John English and Ian M. Drummond. *Canada, 1900-1945*. Toronto: University of Toronto Press, 1987.
- Boydston, Jeanne. "Gender as a Question of Historical Analysis." *Gender & History* 20, no. 3 (2008): 558-83.
- Bramadat, I. J. and K. I. Chalmers. "Nursing Education in Canada: Historical 'Progress' — Contemporary Issues." *Journal of Advanced Nursing* 14, (1989): 719-26.
- Brennan, Damien. "Commentary. the Social Construction of 'Woman's Work': Nursing Labour and Status." *Journal of Nursing Management* 13, no. 4 (2005): 282-85.
- Brennan, Timothy. "Intellectual Labor." *South Atlantic Quarterly* 108, no. 2 (2009): 395-415.
- Cameron, Brenda, Christine Ceci, and Anna Santos Salas. "Nursing and the Political." *Nursing Philosophy* 12, no. 3 (2011): 153-55.
- Canada. Status of Women Canada. *The Royal Commission on the Status of Women: An Overview 25 Years Later*. Ottawa, Ont.?: Status of Women Canada, 1995.
- Carroll, William K. and Rennie Warburton. "Feminism, Class Consciousness and Household-Work Linkages among Registered Nurses in Victoria." *Labour / Le Travail* 24, (1989): 131-45.
- Cash, Keith. "Social Epistemology, Gender and Nursing Theory." *International Journal of Nursing Studies* 34, no. 2 (1997): 137-43.
- Cavanagh, Sheila L. "Female-Teacher Gender and Sexuality in Twentieth-Century Ontario, Canada." *History of Education Quarterly* 45, no. 2 (2005): 247-73.

- Ceci, Christine. "Gender, Power, Nursing: A Case Analysis." *Nursing Inquiry* 11, no. 2 (2004): 72-81.
- . "Nursing, Knowledge and Power: A Case Analysis." *Social Science & Medicine* (1982) 59, no. 9 (2004): 1879-1889.
- Ceci, Christine and Mary Ellen Purkis. "Means without Ends: Justifying Supportive Home Care for Frail Older People in Canada, 1990-2010." *Sociology of Health & Illness* 33, no. 7 (2011): 1066-1080.
- Choy, Catherine Ceniza. "Nurses Across Borders: Foregrounding International Migration in Nursing History." *Nursing History Review : Official Journal of the American Association for the History of Nursing* 18, (2010): 12-28.
- Choy, Catherine Ceniza, and Inc ebrary. *Empire of Care: Nursing and Migration in Filipino American History*. Durham: Duke University Press, 2003.
- Christie, Nancy. *Households of Faith: Family, Gender and Community in Canada, 1760-1969* McGill-Queen's University Press, 2001.
- Christie, Nancy. *Engendering the State: Family, Work, and Welfare in Canada*. Toronto: University of Toronto Press, 2000.
- . *Households of Faith: Family, Gender and Community in Canada, 1760-1969*. Montréal: McGill-Queen's University Press, 2002.
- Cobble, Dorothy Sue. *The Other Women's Movement : Workplace Justice and Social Rights in Modern America*. Politics and Society in Twentieth-Century America. 1st paperback ed. Oxford [UK]: Princeton University Press, 2004.
- Coburn, David. "Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective." *Labour / Le Travail* 34, (1994): 139-62.
- Creed, Gerald W. *The Seductions of Community: Emancipations, Oppressions, Quandaries*. Oxford [UK]: School of American Research, 2006.
- Crompton, Rosemary. "Gender, Status and Professionalism." *Sociology* 21, no. 3 (1987): 413-28.
- Cross, Herbert J. and Randall R. Kleinesselink. "The Impact of the 1960s on Adolescence." *The Journal of Early Adolescence* 5, no. 4 (1985): 517-31.
- D'Antonio, Patricia. "Women, Nursing, and Baccalaureate Education in 20th Century America." *Journal of Nursing Scholarship* 36, no. 4 (2004): 379-84.
- D'Antonio, Patricia. "History and the Humanities." *Nursing History Review : Official Journal of the American Association for the History of Nursing* 18, (2010): 10-11.

- Das Gupta, Tania. *Real Nurses and Others: Racism in Nursing*. Black Point, NS: Fernwood Pub, 2009.
- Dewis, MEM and F. J. Grenier. "Partnership in Education: Working Toward the Baccalaureate Degree as Entry to Nursing Practice in Canada." *Journal of Advanced Nursing* 18, no. 7 (1993): 1016-1022.
- Dodd, Dianne E. and Deborah Gorham. *Caring and Curing: Historical Perspectives on Women and Healing in Canada*. Vol. 18. Ottawa: University of Ottawa Press, 1994.
- Dodd, Dianne. "Nurses' Residences: Using the Built Environment as Evidence." *Nursing History Review* 9, (2001): 185-206.
- Dodd, Dianne E., Nicole Rousseau, and Christina Bates. *On all Frontiers: Four Centuries of Canadian Nursing*. Ottawa: University of Ottawa Press, 2005.
- Downey, Maude, Linda Green, Stacey Johnson, Dorothy M. Pringle, and Nursing Sector Study Corporation. *Nursing Education in Canada: Historical Review and Current Capacity*. Ottawa: Nursing Sector Study Corporation, 2004.
- Edwards, Elizabeth. *Women in Teacher Training Colleges, 1900-1960: A Culture of Femininity*. London: Routledge, 2001.
- Elbourne, Elizabeth. *Gender, Colonialism, and Faith*. Baltimore Maryland: Johns Hopkins University Press, 2013.
- Elliott, Jayne, Meryn Elisabeth Stuart, and Cynthia Toman. *Place and Practice in Canadian Nursing History*. Vancouver: UBC Press, 2008.
- Fairman, Juline. "Not all Nurses are Good, Not all Doctors are Bad." *Bulletin of the History of Medicine* 78, no. 2 (2004): 451-60.
- Finkel, Alvin. *Our Lives: Canada After 1945*. Toronto, ON: James Lorimer & Co, 2012.
- Finnie, Ross, Arthur Sweetman, and Eric Lascelles. *Who Goes? the Direct and Indirect Effects of Family Background on Access to Post-Secondary Education*. Research Paper Series, no. 237. Ottawa: Statistics Canada, Analytical Studies Branch, 2005.
- Flynn, Karen. "Beyond the Glass Wall: Black Canadian Nurses, 1940-1970." *Nursing History Review* 17, (2009): 129-52.
- Flynn, Karen. "Beyond the Glass Wall: Black Canadian Nurses, 1940-1970." *Nursing History Review : Official Journal of the American Association for the History of Nursing* 17, (2009): 129-52.

- Franzway, Suzanne. "Sisters and Sisters? Labour Movements and Women's Movements in (English) Canada and Australia." *Hecate* 26, no. 2 (2000): 31-46.
- Freeman, Barbara M. "The Media and the Royal Commission on the Status of Women in Canada, 1966-1972." *Resources for Feminist Research* 23, no. 3 (1994): 3-10.
- Gascoigne, John. "Introduction: Religion and Empire, an Historiographical Perspective." *Journal of Religious History* 32, no. 2 (2008): 159-78.
- Gastaldo, Denis and Dave Holmes. "Foucault and Nursing: A History of the Present." *Nursing Inquiry* 6, no. 4 (1999): 231-40.
- Gastaldo, Denise and Dave Holmes. "Foucault and Nursing: A History of the Present." *Nursing Inquiry* 6, no. 4 (1999): 231-40.
- Gebbie, Kristine M. "20th-Century Reports on Nursing and Nursing Education: What Difference did they make?" *Nursing Outlook* 57, no. 2 (2009): 84-92.
- Glazer, Nona Y. "'Between a Rock and a Hard Place': Women's Professional Organizations in Nursing and Class, Racial, and Ethnic Inequalities." *Gender and Society* 5, no. 3, Special Issue: Marxist Feminist Theory (1991): 351-72.
- Gleason, Mona. "Embodied Negotiations: Children's Bodies and Historical Change in Canada, 1930 to 1960." *Journal of Canadian Studies - Review De Etudes Canadiennes* 34, no. 1 (1999): 112-38.
- . "Psychology and the Construction of the 'Normal' Family in Postwar Canada, 1945-60." *Canadian Historical Review* 78, no. 3 (1997): 442-77.
- Gleason, Mona. *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada*. Toronto, Ont: University of Toronto Press, 1999.
- Glegg, Alastair. "Right-Minded Teachers: The Influence of the Socio-Political Context on the Preparation of Teachers in British Columbia, 1872-2002." *Journal of Educational Administration & History* 37, no. 1 (2005): 19-37.
- Gluck, Sherna Berger and Daphne Patai. *Women's Words : The Feminist Practice of Oral History*. New York: Routledge, 1991.
- Gordon, Colin. "Governmental Rationality: An Introduction" in *The Foucault Effect: Studies in Governmentality* ed. Graham Burchell, Colin Gordon, Peter Miller. Chicago: University of Chicago Press, 1991.

- Gordon, Tina. "Profits and Prejudice: The Undervalued Work of Nursing." *Dollars & Sense* no. 231 (2000): 26-38.
- Grypma, Sonya Joy. *Healing Henan: Canadian Nurses at the North China Mission, 1888-1947*. Vancouver: UBC Press, 2008.
- _____. "Profile of a Leader: Unearthing Ethel John's "Buried" Commitment to Racial Equality, 1925." *Nursing Leadership* 16, no. 4 (2003): 39-47.
- Handcock, Mark S. and Krista J. Gile. "Comment: On The Concept Of Snowball Sampling." *Sociological Methodology* 41, no. 1 (2011): 367-71.
- Haynes, Kathryn. "Other Lives in Accounting: Critical Reflections on Oral History Methodology in Action." *Critical Perspectives on Accounting* 21, no. 3 (2010): 221-31.
- Hegge, Margaret J. "The Lingering Presence of the Nightingale Legacy." *Nursing Science Quarterly* 24, no. 2 (2011): 152-62.
- Henderson, A. "Power and Knowledge in Nursing Practice: The Contribution of Foucault." *Journal of Advanced Nursing* 20, no. 5 (1994): 935-39.
- Herdman, E. A. "The Illusion of Progress in Nursing." *Nursing Philosophy* 2, no. 1 (2001): 4-13.
- Hiscott, Robert Dennis. *Career Paths of Nursing Professionals: A Study of Employment Mobility*. Ottawa: Carleton University Press, 1998.
- Holliday, M. E. and D. L. Parker. "Florence Nightingale, Feminism and Nursing." *Journal of Advanced Nursing* 26, no. 3 (1997): 483-88.
- Holmes, Dave and Denise Gastaldo. "Nursing as Means of Governmentality." *Journal of Advanced Nursing* 38, no. 6 (2002): 557-65.
- Iacovetta, Franca and Mariana Valverde. *Gender Conflicts : New Essays in Women's History*. The Social History of Canada, 0085-6207 ; 46. Toronto: University of Toronto Press, 1992.
- Iacovetta, Franca. "Recipes for Democracy? Gender, Family, and Making Female Citizens in Cold War Canada." *Canadian Woman Studies* 20, no. 2 (2000): 12-21.
- Ilon, Lynn. "Knowledge, Labour and Education." *Compare: A Journal of Comparative and International Education* 30, no. 3 (2000): 275-82.
- Joan Wallach Scott. "Feminist Reverberations." *Differences* 13, no. 3 (2002): 1-23.
- Kane, Deborah and Barbara Thomas. "Nursing and the 'F' Word." *Nursing Forum* 35, no. 2 (2000): 17-24.

- Kealey, Linda and Franca Iacovetta. "Women's History, Gender History and Debating Dichotomies." *Left History* (1996): 221-37.
- Keddy, B., M. J. Gillis, P. Jacobs, H. Burton, and M. Rogers. "The Doctor-Nurse Relationship: An Historical Perspective." *Journal of Advanced Nursing* 11, no. 6 (1986): 745-53.
- Keddy, Barbara and Dianne Dodd. "The Trained Nurse: Private Duty and VON Home Nursing (Late 1800s to 1940s)." in *On all Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne E. Dodd, and Nicole Rousseau. Ottawa: University of Ottawa Press, 2005: 43-55.
- Keller, Evelyn Fox. "Kuhn, Feminism, and Science?" *Configurations* 6, no. 1 (1998): 15-19.
- Kelly, Nora. *Quest for a Profession: The History of the Vancouver General Hospital School of Nursing*. Vancouver, British Columbia: Evergreen Press, 1973.
- Kelm, Mary Ellen. *Colonizing bodies: aboriginal health and healing in British Columbia, 1900-50* 1998. UBC Press, Vancouver, 1998.
- Kessler-Harris, Alice. *Gendering Labor History. Working Class in American History*. Urbana: University of Illinois Press, 2006.
- Kinnear, J. L. "The Professionalization of Canadian Nursing, 1924-32: Views in the CN and the CMAJ." *Canadian Bulletin of Medical History = Bulletin Canadien d'Histoire De La Médecine* 11, no. 1 (1994): 153-74.
- Kirkwood, R. "Blending Vigorous Leadership and Womanly Virtues: Edith Kathleen Russell at the University of Toronto, 1920-52." *Canadian Bulletin of Medical History/Bulletin Canadien d'Histoire De La Médecine* 11, (1994): 175-205.
- Korinek, Valerie Joyce. *Roughing it in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties*. Vol. 16. Toronto: University of Toronto Press, 2000.
- Kuhn, Thomas S. *The Structure of Scientific Revolutions*. Chicago, IL: University of Chicago Press, 1996.
- Levine, Philippa. *Gender and Empire*. New York: Oxford University Press, 2004.
- Light, Beth and Ruth Roach Pierson. *No Easy Road : Women in Canada 1920s to 1960s*. Documents in Canadian Women's History ; v. 3. Toronto: New Hogtown Press, 1990.
- Lutz, Helma, Linda Supik, and Maria Teresa Herrera Vivar. *Framing Intersectionality: Debates on a Multi-Faceted Concept in Gender Studies*. Burlington, VT: Ashgate Pub, 2011.
- Luxton, Meg. "Feminism as a Class Act: Working-Class Feminism and the Women's Movement in Canada." *LABOUR-LE TRAVAIL* no. 48 (2001): 63-88.

- Lynch, Kathleen and John Baker. "Equality in Education: An Equality of Condition Perspective." *Theory and Research in Education* 3, no. 2 (2005): 131-64.
- Malka, Susan Gelfand. *Daring to Care : American Nursing and Second-Wave Feminism*. Urbana: University of Illinois Press, 2007.
- Mansell, Diana. *Forging the Future : A History of Nursing in Canada*. Ann Arbor, Mich: Thomas Press, 2004.
- Mansell, Diana and Dianne Dodd. "Professionalism and Canadian Nursing," in *On All Frontiers*, eds. Dianne E. Dodd, Nicole Rousseau, and Christina Bates. Ottawa: University of Ottawa Press, 2005: 197-212.
- Marks, Lynne. "Challenging Binaries: Working-Class Women and Lived Religion in English Canada and the United States." *Labor: Studies in Working-Class History of the Americas* 6, no. 1 (2009): 107-25.
- Marshall, Barbara L. "Studying the Second Wave: Recent Work on the Canadian Women's Movement." *Journal of Canadian Studies/Revue d'Études Canadiennes* 29, no. 4 (1994): 162-70.
- McPherson, Kathryn and Meryn Stuart. "Writing Nursing History in Canada: Issues and Approaches." *Canadian Bulletin of Medical History / Bulletin Canadien d'Histoire De La Médecine* 11, no. 1 (1994): 3-22.
- McPherson, Kathryn. *Bedside Matters: The Transformation of Canadian Nursing 1900–1990*. Toronto: Oxford University Press. 1996.
- McPherson, Kathryn. "The Case of the Kissing Nurse." In *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada*, ed. Cecilia Louise Morgan, Nancy M. Forestell, and Kathryn M. McPherson. Don Mills, ON: Oxford University Press, 1999.
- McPherson, Kathryn. "The Nightingale Influence and the Rise of the Modern Hospital." in *On all Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne E. Dodd, and Nicole Rousseau. Ottawa: University of Ottawa Press, 2005: 73-88.
- McPherson, Kathryn. "Issues in Nursing Undergraduate Education." In *Realities of Canadian Nursing*, ed. Marjorie McIntyre and Carol McDonald. Philadelphia: Lippincott Williams and Wilkins, 2010.
- Melchior, Florence. "Feminist Approaches to Nursing History." *Western Journal of Nursing Research* 26, no. 3 (2004): 340-55.
- Melosh, Barbara. *The Physician's Hand: Work Culture and Conflict in American Nursing*. Philadelphia: Temple University Press, 1982.

- Meyerowitz, Joanne J. *Not June Cleaver: Women and Gender in Postwar America, 1945-1960*. Philadelphia: Temple University Press, 1994.
- Morgan, Sue. "Theorising Feminist History: A thirty - year Retrospective." *Women's History Review* 18, no. 3 (2009): 381-407.
- Moro-Abadia, Oscar. "Thinking about 'Presentism' from a Historian's Perspective: Herbert Butterfield and Helene Metzger." *History of Science* 47, no. 1 (2009): 55-77.
- Mussallem, Helen K. *Nursing Education in Canada (Submission to the Royal Commission on Health Services)*. Ottawa ON, 1960.
- . *Spotlight on Nursing Education*. Ottawa ON: Canadian Nurses Association, 1960.
- Mussallem, Helen Kathleen. "A Path to Quality: Plan for the Development of Nursing Education Programs within the General Educational System of Canada." Ottawa: Canadian Nurses' Association, 1964.
- Mridula Nath Chakraborty. "Constructing the Canadian Citizen." *Herizons* 22, no. 2 (2008): 53-55.
- Nash, J. C. "Re-Thinking Intersectionality." *Feminist Review* no. 89 (2008): 1-15.
- Nelson, Sioban and Anne Marie Rafferty. *Notes on Nightingale: The Influence and Legacy of a Nursing Icon*. Ithaca: ILR Press, 2010.
- Nicholson, Linda J. *The Second Wave : A Reader in Feminist Theory*. New York: Routledge, 1997.
- Noy, Chaim. "Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research." *International Journal of Social Research Methodology* 11, no. 4 (2008): 327-44.
- Opp, James William and John C. Walsh. *Home, Work and Play: Situating Canadian Social History, 1840-1980*. Toronto: Oxford University Press, 2006.
- Owram, Doug. *Born at the Right Time: A History of the Baby-Boom Generation*. Toronto: University of Toronto Press, 1996.
- Palmer, Bryan D. *Canada's 1960s: The Ironies of Identity in a Rebellious Era*. London: University of Toronto Press, 2009.
- Paul, Pauline. "Nursing Education Becomes Synonymous with Nursing Service: The Development of Training Schools." in *Prepared to Care: Nurses and Nursing in Alberta*, ed. Janet C. Ross-Kerr (Edmonton: The University of Alberta Press, 1998): 129-48.
- Parr, Joy. *Domestic Goods: The Material, the Moral, and the Economic in the Postwar Years*. Toronto: University of Toronto Press, 1999.

- . "Gender History and Historical Practice." *Canadian Historical Review* 76, no. 3 (1995): 354-76.
- Perks, Robert and Alistair Thomson. *The Oral History Reader*. London: Routledge, 1998.
- Pieper, Katherine. "The Other Women's Movement: Workplace Justice and Social Rights in Modern America, by Dorothy Sue Cobble." *Women's Studies in Communication* 28, no. 1 (2005): 149-51.
- Pierson, Ruth Roach. *They'Re Still Women After all: The Second World War and Canadian Womanhood*. Toronto: McClelland and Stewart, 1986.
- Pinnick, Cassandra L. "Feminist Epistemology: Implications for Philosophy of Science." *Philosophy of Science* 61, no. 4 (1994): 646-57.
- Reimer-Kirkham, S. "Lived Religion: Implications for Nursing Ethics." *Nursing Ethics* 16, no. 4 (2009): 406-17.
- Reverby, Susan. *Ordered to Care : The Dilemma of American Nursing, 1850-1945*. Cambridge History of Medicine. Cambridge New York: Cambridge University Press, 1987.
- Richardson, Sharon L. "“Stand Up and be Counted”: Nursing at the Calgary General Hospital After the Second World War." *Canadian Bulletin of Medical History* 18, no. 2 (2001): 297-323.
- Risjord, Mark W. *Nursing Knowledge: Science, Practice, and Philosophy*. Ames, Iowa: Wiley-Blackwell Pub, 2010.
- Roberts, Lance W. *Recent Social Trends in Canada, 1960-2000*. Comparative Charting of Social Change. Montreal ; London: McGill-Queen's University Press, 2005.
- Ross Kerr, Janet C. "Milestones in Canadian Nursing History." *Journal of Professional Nursing* 8, no. 3 (1992): 139.
- Roth, Mark. "The Gendered Workings of Class in Postindustrial, Service Sector Capitalism: The Emergence and Evolution of the British Columbia Nurses Union, 1976-1992." Masters Thesis. Simon Fraser University, 2008.
- Sandelowski, M. *Devices and Desires: Gender, Technology and American Nursing* University of North Carolina Press, 2000.
- Sangster, Joan. "Feminism and the Making of Canadian Working-Class History: Exploring the Past, Present and Future." *Labour / Le Travail* 46, (2000): 127-65.
- . "Radical Ruptures: Feminism, Labor, and the Left in the Long Sixties in Canada." *American Review of Canadian Studies* 40, no. 1 (2010): 1-21.

- Sangster, Joan. *Transforming Labour: Women and Work in Post-War Canada*. Toronto: University of Toronto Press, 2010.
- Scott, Joan W. "Feminism's History." *Journal Of Women's History* 16, no. 2 (2004): 10-29.
- Simonton, Deborah. "Nursing History as Women's History," *International History of Nursing Journal* 6, no. 1 (1999): 35-47.
- Sandelowski, Marguerite, *Devices and Desires: Gender, Technology, and American Nursing* (Charlotte NC: University of North Carolina Press, 2000).
- Smith, James P. "Nursing, Women's History and the Politics of Welfare." *Journal of Advanced Nursing* 19, no. 3 (1994): 609-12.
- Smyth, Elizabeth M. *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work*. Toronto: University of Toronto Press, 1999.
- Strong-Boag, Veronica. "Canada's Wage-Earning Wives and the Construction of the Middle Class, 1945-60." *Journal of Canadian Studies* 29, no. 3 (1994): 5-25.
- Strong-Boag, V. "Making a Difference: The History of Canada's Nurses." *Canadian Bulletin of Medical History / Bulletin Canadien d'Histoire De La Médecine* 8, no. 2 (1991): 231-48.
- Sullivan, Eleanor J. "Nursing and Feminism: An Uneasy Alliance." *Journal of Professional Nursing* 18, no. 4 (7, 2002): 183-84.
- Summerfield, Penny. *Reconstructing Women's Wartime Lives*. Manchester UK: Manchester University Press, 1998.
- Thomson, Alistair. "Four Paradigm Transformations in Oral History." *Oral History Review* 34, no. 1 (2007): 49-70.
- Timpson, Annis May. *Driven Apart: Women's Employment Equality and Child Care in Canadian Public Policy*. Vancouver: UBC Press, 2001.
- Toman, Cynthia. "'Body Work': Nurses and the Delegation of Medical Technology at the Ottawa Civic Hospital, 1947-1972." *Scientia Canadensis* 29, no. 2 (2006): 155-75.
- Toman, Cynthia. *An Officer and a Lady: Canadian Military Nursing and the Second World War*. Vancouver: UBC Press, 2007.
- Toman, Cynthia and Marie-Claude Thifault. "Historical Thinking and the Shaping of Nursing Identity." *Nursing History Review* 20, (2012): 184-204.
- Turkoski, Barbara B. "Professionalism as Ideology: A Socio-Historical Analysis of the Discourse of Professionalism in Nursing." *Nursing Inquiry* 2, no. 2 (1995): 83-89.

- Valentine, Patricia E. B. "Nursing: A Ghettoized Profession Relegated to Women's Sphere." *International Journal of Nursing Studies* 33, no. 1 (1996): 98-106.
- Van der Lippe, Tanja and Liset van Dijk. "Comparative Research on Women's Employment." *Annual Review of Sociology* 28, no. 1 (2002): 221-41.
- Van Herk, Kimberley A., Dawn Smith, and Caroline Andrew. "Examining our Privileges and Oppressions: Incorporating an Intersectionality Paradigm into Nursing." *Nursing Inquiry* 18, no. 1 (2011): 29-39.
- Villeneuve, Michael and Jane MacDonald, Principal Investigators. *Toward 20/20: Visions for Nursing*. Ottawa: Canadian Nurses Association, 2006.
- Violette, Brigitte. "Healing the Body and Saving the Soul: Nursing Sisters and the First Catholic Hospitals in Quebec (1639–1880)." in *On all Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne E. Dodd, and Nicole Rousseau. Ottawa: University of Ottawa Press, 2005: 57-71.
- Wall, Barbara Mann. "The Place of Religion as an Interpretive Tool in Nursing History." *Nursing History Review: Official Journal of the American Association for the History of Nursing* 18, no. 1 (2010): 130-3.
- Warbinek, Ethel, Glennis Zilm, and University of British Columbia. School of Nursing. *Legacy: History of Nursing Education at the University of British Columbia, 1919-1994*. Vancouver: University of British Columbia School of Nursing, 1994.
- Weir, George. *Survey of Nursing Education in Canada*. Toronto ON: University of Toronto Press, 1932.
- Wuest, J. "Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective." *Journal of Professional Nursing* 10, no. 6 (1994): 357-67.
- Yow, Valerie. "Ethics and Interpersonal Relationships in Oral History Research." *The Oral History Review* 22, no. 1 (1995): 51-66.
- Yow, Valerie Raleigh. *Recording Oral History: A Guide for the Humanities and Social Sciences*. Walnut Creek, CA: AltaMira Press, 2005.

Appendix A: Table of Participants

<i>Schools of Nursing in Vancouver British Columbia</i>								
<i>UBC: University of British Columbia School of Nursing (Greater Vancouver)</i>								
<i>St. Paul's: St. Paul's Hospital School of Nursing (Greater Vancouver)</i>								
<i>VGH: Vancouver General Hospital School of Nursing (Greater Vancouver)</i>								
<i>RCH: Royal Columbian Hospital School of Nursing (New Westminster)</i>								
<i>Pseudonym</i>	<i>School Attended and location</i>	<i>Length of program and degree of diploma</i>	<i>Age at time of nursing school entry/ graduation</i>	<i>Year of entry/ graduation</i>	<i>Part time, full time work in nursing</i>	<i>Highest level of education obtained</i>	<i>Age at marriage if applicable</i>	<i>Age at birth of first child if applicable</i>
<i>1. Vera</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>19/22</i>	<i>1958/1962</i>	<i>Pt/Ft</i>	<i>PhD</i>	<i>30</i>	<i>32/34</i>
<i>2. Paula</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>19/22</i>	<i>1962/1967</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>-</i>	<i>-</i>
<i>3. Val</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>19/23</i>	<i>1963/1967</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>23</i>	<i>-</i>
<i>4. Beth</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>16/21</i>	<i>1963/1967</i>	<i>Resigned in 1972</i>	<i>BScN</i>	<i>20</i>	<i>26/29</i>
<i>5. Meg</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>19/22</i>	<i>1963/1967</i>	<i>Pt/Ft</i>	<i>Masters in Public Health</i>	<i>-</i>	<i>-</i>
<i>6. Kelly</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>19/24</i>	<i>1963/1967</i>	<i>Pt/Ft</i>	<i>Masters</i>	<i>24</i>	<i>27/29</i>
<i>7. Cora</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>18/22</i>	<i>1966/1971</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>22</i>	<i>28/31</i>
<i>8. Dawn</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>18/22</i>	<i>1971/1976</i>	<i>Pt/Ft</i>	<i>Master in Leadership</i>	<i>22</i>	<i>26/29</i>
<i>9. Dora</i>	<i>UBC</i>	<i>4 yr. Deg</i>	<i>17/21</i>	<i>1973/1977</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>24</i>	<i>28/31/34</i>
<i>10. Karen</i>	<i>St. Paul's</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1958/1961</i>	<i>Resigned in 1962</i>	<i>Diploma</i>	<i>22</i>	<i>23/25/29/30</i>
<i>11. Mary</i>	<i>St. Paul's</i>	<i>3 yr. Dip</i>	<i>18/24</i>	<i>1961/1967</i>	<i>Pt/Ft</i>	<i>MSN</i>	<i>19</i>	<i>27</i>
<i>12. Corrine</i>	<i>St. Paul's</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1962/1965</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>21</i>	<i>21/26/29</i>
<i>13. Betty</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1962/1965</i>	<i>Pt/Ft</i>	<i>BN and Nursing Management Diploma</i>	<i>24</i>	<i>24/26</i>
<i>15. Sara</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1963/1966</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>22</i>	<i>23/26/29</i>
<i>16. Shirley</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1964/1967</i>	<i>Resigned in 1969</i>	<i>Diploma</i>	<i>21</i>	<i>24/28</i>
<i>17. Monica</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1964/1967</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>22</i>	<i>25/27</i>
<i>17. Wanda</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>19/21</i>	<i>1966/1969</i>	<i>Pt/Ft</i>	<i>BSN/MSN</i>	<i>21</i>	<i>23/26</i>
<i>18. Gail</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1968/1972</i>	<i>Pt/Ft</i>	<i>Specialty in Nursing</i>	<i>28</i>	<i>33/35</i>
<i>19. Joan</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>17/20</i>	<i>1968/1971</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>21</i>	<i>25/28</i>
<i>20. Jill</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>20/23</i>	<i>1971/1974</i>	<i>Pt/Ft</i>	<i>Specialty in Nursing</i>	<i>20</i>	<i>33</i>

21. <i>Moira</i>	<i>VGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1971/1974</i>	<i>Pt/Ft</i>	<i>MScN</i>	<i>21</i>	<i>-</i>
22. <i>Rona</i>	<i>RCH</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1962/1965</i>	<i>Pt/Ft</i>	<i>Specialty Certificate Nursing</i>	<i>24</i>	<i>27/29/37</i>
<i>Schools of Nursing in Calgary Alberta</i>								
<i>Holy Cross: Holy Cross Hospital School of Nursing Calgary</i>								
<i>Foothills Hospital: Foothills Hospital School of Nursing Calgary</i>								
<i>CGH: Calgary General Hospital School of Nursing Calgary</i>								
<i>Pseudonym</i>	<i>School Attended and location</i>	<i>Length of program: degree or diploma</i>	<i>Age at time of nursing school entry/ graduation</i>	<i>Year of entry/ graduation</i>	<i>Part time, full time work in nursing</i>	<i>Highest level of education obtained</i>	<i>Age at marriage if applicable</i>	<i>Age at birth of first child if applicable</i>
23. <i>Penny</i>	<i>Holy Cross</i>	<i>3 yr. Dip</i>	<i>17/20</i>	<i>1958/1961</i>	<i>Pt/Ft</i>	<i>BN</i>	<i>35</i>	<i>37/39</i>
24. <i>Audrey</i>	<i>Holy Cross</i>	<i>3yr. Dip</i>	<i>18/21</i>	<i>1961/1964</i>	<i>Pt/Ft</i>	<i>Specialty in Nursing</i>	<i>22</i>	<i>23/27</i>
25. <i>Peggy</i>	<i>Holy Cross</i>	<i>3yr. Dip</i>	<i>19/21</i>	<i>1966/1969</i>	<i>Pt/Ft</i>	<i>Masters of Nursing</i>	<i>33</i>	<i>34/38</i>
26. <i>Deanne</i>	<i>Holy Cross</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1970/1973</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>23</i>	<i>30/34</i>
27. <i>Cathy</i>	<i>Foothills Hospital</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1969/1971</i>	<i>Pt/Ft</i>	<i>PhD</i>	<i>18</i>	<i>29</i>
28. <i>Maria</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>19/22</i>	<i>1959/1962</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>22</i>	<i>23/24</i>
29. <i>Mona</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1961/1964</i>			<i>20</i>	<i>23</i>
30. <i>Anne</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1961/1964</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>21</i>	<i>29/35</i>
31. <i>Gina</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1961/1964</i>	<i>Pt/Ft</i>	<i>MA</i>	<i>26</i>	<i>36/39</i>
32. <i>Jackie</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1961/1964</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>21</i>	<i>22</i>
33. <i>Bev</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/23</i>	<i>1961/1966</i>	<i>Pt/Ft</i>	<i>Specialty in Nursing</i>	<i>20</i>	<i>20</i>
34. <i>Dina</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/21</i>	<i>1962/1965</i>	<i>Pt/Ft</i>	<i>BScN</i>	<i>20</i>	<i>21/25</i>
35. <i>Pauline</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>18/22</i>	<i>1962/1965</i>	<i>Pt/Ft</i>	<i>Dip in PH</i>	<i>-</i>	<i>-</i>
36. <i>Shelley</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>17/20</i>	<i>1963/1966</i>	<i>Pt/Ft</i>	<i>Diploma</i>	<i>21</i>	<i>21/25</i>
37. <i>Jana</i>	<i>CGH</i>	<i>3 yr. Dip</i>	<i>17/20</i>	<i>1971/1974</i>	<i>Pt/Ft</i>	<i>MBA</i>	<i>-</i>	<i>-</i>

Appendix B: Recruitment Letter

Research Project Title: UNDERSTANDING WOMEN'S LABOUR, 1958-1977: WORK, NURSING, AND MOTHERHOOD

This is an invitation to participate in a research study. The purpose of the study is to discover, through audio-taped confidential conversation in the location of your choice or over the telephone, your unique experience of being a nurse in western Canada the 1960s and early 1970s. Participation in this study is entirely voluntary, and if you agree to participate, you may change your mind and withdraw at any point without the need for explanation.

These conversations will be relatively unstructured, but some questions could include:

“ What was your experience of becoming a nurse in western Canada in the 1960s and early 1970s and did your role as a woman at that time influence that experience?”

If this is of interest to you, please call or email Margaret Scaia, RN, MN, PhD (C) of the University of Victoria. I can be reached at 250-721-7963 to leave a confidential voice mail message, or email to mrscaia@uvic.ca

Appendix C: Participant Consent Form and Demographic Questionnaire

You are invited to participate in a study entitled:

UNDERSTANDING WOMEN'S LABOUR, 1958-1977: WORK, NURSING AND MOTHERHOOD



Participant Consent Form and Demographic Questionnaire

You are invited to participate in a study entitled: UNDERSTANDING WOMEN'S LABOUR, 1958-1977: WORK, NURSING AND MOTHERHOOD that is being conducted by Margaret Scaia, RN, MN, PhD (C).

Margaret Scaia is an Interdisciplinary PhD student and faculty member in the School of Nursing at the University of Victoria. You may contact Margaret Scaia, the Principal Investigator, at 250-721-7963 or mrscaia@uvic.ca.

As a graduate student, I am required to conduct research as part of the requirements for an Interdisciplinary PhD in Nursing, History and Women's Studies. It is being conducted under the supervision of Dr. M.E. Purkis. You may contact my supervisor at (Phone: 250.721.8050/ Email: hsd dean@uvic.ca).

The Social Sciences and Humanities Research Council is funding this research.

Purpose and Objectives

The purpose of this research project is to generate new understandings about your experience as a nurse for which we currently have limited understanding and to possibly challenge assumptions about the experience of nursing in western Canada in the 1960s and early 1970s, particularly in Calgary and Vancouver.

Importance of this Research

Research of this type will make an important contribution to scholarship related to the history of nursing and will shed light on current issues and debates about women's changing social roles. The analysis of your interview will serve as a primary source document in my PhD dissertation looking at the social construction of nursing and women's roles in Canadian society at this critical time in women's history.

Participants Selection

You are being asked to participate since you responded to my email notice or personal invitation, you received your nursing education and diploma or degree in nursing in the 1960s and early 1970s, and you speak English.

What is involved:

If you agree to participate in the study, it will include a 15 minute demographic questionnaire and a 75 minute audio-taped conversation. If feasible, the conversation will take place in person, if not feasible, then by telephone. The interview will be audio-recorded. The recording will be used to create a transcript for study by the researcher and will not be used in the dissemination of the results of the study. Information gathered from the demographic questionnaire will also not be linked to your transcript or identified in the analysis of your interview. Your words may be used in direct quotes, but at no time will you be linked with your specific quote. This interview will take the form of conversations about your experiences of nursing, marriage and motherhood during the time period indicated earlier. You will largely direct the conversation with some help provided by a few questions such as:

“What was your experience of becoming a nurse in western Canada in the 1960s and early 1970s and did your role as a woman at that time influence that experience?”

“How did your role as a woman influence your experience of being a nurse during this time period?”

“What other factors were significant in shaping your experience of being a nurse during this time period?”

“What meaning do you now make of being a nurse during this time period?”

“What questions about the experience of being a nursing during this time period have not been asked in this interview and that are important for me to know about?”

Inconvenience

Participation in this study may cause some inconvenience to you, in particular the 90 minutes required to complete the 15 minute demographic questionnaire and the 75 minute audio-taped conversation.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

To the Participant:

You will have the opportunity to talk about the joys experienced and the challenges faced during their early nursing education and career. You will have the satisfaction of knowing that sharing their experiences will enhance society's understanding of the profession of nursing and the role of women in society – particularly in the post-war period in western Canada.

To Society:

The education and professional standing of nurses is of primary importance to society. In a time of reduced numbers of nurses available to fill positions in nursing it is vital that more nurses are attracted to, educated in, and enter the profession. The role of nursing in today's Canadian context and the historical and social factors that have both challenged and promoted the profession reflect wider trends in women's work experience and social roles. This study will contribute to a greater understanding of the role of women's labour, the impact of marriage and motherhood on women's labour, and the role of nursing in shaping current attitudes toward women's participation in the social and economic

benefits of Canadian citizenship. The outcome of this study would make a significant contribution not only to nursing history, but also to the history of women's labour, Canadian history and feminist history.

Voluntary Participation

Your participation in the study must be completely voluntary. You may answer as much or as little of the demographic questionnaire or interview questions as you are comfortable with. If you do decide to participate, you may withdraw at any time without any explanation or consequences. If you do not provide consent for use of information gathered before your withdrawal, all information materials will be destroyed and not used in the study.

On-going Consent

After the first interview, consent will be revisited in the same manner as described above and another consent obtained. Should a follow up interview be required for the purposes of clarification, then the steps identified above will be followed to obtain ongoing consent.

Anonymity and Confidentiality

As the nursing community in the 1960s and 1970s in Calgary and Vancouver may be limited in numbers, it may be possible that participants are known to each other, and to the researcher. I will give each participant a pseudonym and I will not identify the specific location of the school from which the participant obtained their nursing education, nor their place of employment following graduation; however, the city – either Calgary or Vancouver will be named. The anonymity of the participants the confidentiality of the data will be preserved as much as possible under these circumstances by storing audio-tapes, demographic questionnaires and any printed transcripts in a locked cabinet in the researcher's office and typed information/transcripts in password protected files on the researcher's work computer. Information obtained from the demographic questionnaire will not be linked to the audio-taped transcripts. Only the researcher will have access to the original data.

In publishing this material, all identifying information will be removed so as to protect your privacy. You will be asked to choose a pseudonym during the interview for use in the dissemination of results.

Dissemination of Results

It is anticipated that the results of this study will be used as part of the analysis of data for my PhD dissertation. I may present parts of this analysis during scholarly conferences or in scholarly articles related to the dissertation focus. I may also publish my dissertation. All assurances of anonymity and confidentiality will be consistent with the above statements in any dissemination of the results of this study.

Disposal of Data

The data will be archived in the principal researcher's private office in a locked filing cabinet and/or a password protected computer file. Once the 7 year time limit has passed, all data will be destroyed by either shredding or permanent deletion from computer files.

Contacts

You may contact Margaret Scaia regarding this study at 250-721-7963 or mrscaia@uvic.ca.

You may verify the ethical approval of this study or raise any concerns you may have by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca.

Your signature or the signature indicates that you understand the above conditions of participating in this study and that you have had an opportunity to have your questions answered by the researchers. A copy of this consent will be faxed, mailed, or left with you, and the researcher will retain a copy.

Protocol Number 10-458

_____	_____	_____
Name of participant	Signature (participant or researcher)	Date (interview)
_____	_____	_____

Demographic Questionnaire

Research Project Title: UNDERSTANDING WOMEN'S LABOUR, 1958-1977: WORK,
NURSING AND MOTHERHOOD

Participant code number: _____

Date and location of birth of narrator: _____

Date and location of entry to nursing education: _____

Date and location where nursing diploma or degree was received: _____

Age at entry to nursing education: _____

Age at completion of nursing education: _____

Length of nursing education: _____

Highest level of nursing education obtained: _____

Location of highest level of nursing education: _____

Chronology of nursing employment

Location of employment	Dates of employment	Reason for terminating employment

Your age upon first marriage: _____

Your age upon birth of first and subsequent children: _____

Other comments related to nursing education and employment: _____

Appendix D: Ethics Approval



**University
of Victoria**

Human Research Ethics Board Application for Ethics Approval for Human Participant Research

The following application form is an institutional protocol based on the [Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans](#)

Instructions:

1. Download this application and complete it on your computer. Hand written applications will not be accepted. The ethical review process takes 4 - 6 weeks.
2. Use the *Human Research Ethics Board Guidelines* to complete this application: <http://www.research.uvic.ca/Forms/>. Note: This form is linked to the guidelines. Access links in blue text by hitting CTRL and clicking on the blue text.
3. Submit one (1) original and two (2) copies of this completed, signed application with all attachments to: Human Research Ethics, Administrative Services Building (ASB), Room B202, University of Victoria, PO Box 1700 STN CSC, Victoria BC V8W 2Y2 Canada
4. If you need assistance, contact the Human Research Ethics Assistant at (250) 472-4545 or ethics@uvic.ca
5. Please note that applications are screened and will be returned to the applicant if incomplete (e.g. missing required attachments, signatures, documents).
6. Once approved, a Request for Renewal must be completed annually for on-going projects for continuing Ethics approval.

A. [Principal Investigator](#)

If there is more than one *Principal Investigator*, provide their name(s) and contact information below in Section B, *Other Investigator(s) & Research Team*.

Last Name: **Scaia** First Name: **Margaret**

Department/Faculty: **Nursing** Email: **mrscaia@uvic.ca**

Phone: **250-721-7963** Fax: **250-721-6231**

Mailing Address including Postal Code:

(if different from Dept/Faculty)

Title/Position:

- Faculty Undergraduate Ph.D. Student
 Staff Master's Student Post-Doctoral

Students: Provide your Supervisor's:

Name: **Dr. Mary Ellen Purkis** Email: **hsddean@uvic.ca**

Department/Faculty: **Nursing** Phone: **250-721-8050**

Graduate Students: Provide your Graduate Secretary's email address: cotes@uvic.ca

B. [Project Information](#)

Project Title: UNDERSTANDING WOMEN'S LABOUR, 1958-1977: WORK, NURSING AND MOTHERHOOD

Anticipated Start Date: **November 2010**

Anticipated End Date: **August 2012**

Geographic location(s) of study: **Vancouver and Calgary**

Keywords: **1. Oral history 2. Women's history 3. Nursing history 4. Gender history**

Is this application connected/associated/linked to one that has been recently submitted? Yes No

If yes, provide further information:

Other Investigator(s) and Research Team:

(Include co-investigators, students, employees, volunteers, community organizations. The form will expand.)

Contact Name	Role in Research Project	Institutional Affiliation	Email or Phone
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Student/Research Assistant

Email or Phone

C. [Agreement and Signatures](#)**Principal Investigator and Student Supervisor affirm that:**

- *I have read this application and it is complete and accurate.*
- *The research will be conducted in accordance with the University of Victoria regulations, policies and procedures governing the ethical conduct of research involving human participants.*
- *The conduct of the research will not commence until Ethics approval has been granted.*
- *The researcher(s) will seek further HREB review if the research protocol is modified.*
- *Adequate supervision will be provided for students and/or staff.*

Principal Investigator Student's Supervisor_____
Signature_____
Signature_____
Print Name_____
Print Name_____
Date Date**Chair, Director or Dean**

I affirm that adequate research infrastructure is available for the conduct and completion of this research.

Signature_____
Print Name_____
DateD. [Project Funding](#)Have you applied for funding for this project? Yes NoHas notice of award been received? Yes No

If yes, please complete the following:

Source(s) of Project Funding*Social Sciences and Humanities Research Council
(SSHRC)***Project Title used in Funding Application(s)**UNDERSTANDING WOMEN'S LABOUR, 1958-1977:
WORK, NURSING AND MOTHERHOODWill this project receive funding from US Funders (e.g. NIH)? Yes No

If yes, provide further information:

E. [Level of Risk](#)The [Tri-Council Policy Statement](#) (TCPS) definition of "minimal risk" is as follows:

The research can be regarded as within the range of minimal risk if potential participants can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the participant in those aspects of his or her everyday life that relate to the research. The designation of minimal or non-minimal risk affects the way the application is reviewed not the substance of the ethical review.”

Based on this definition, do you believe your research qualifies as “minimal risk” research?

Yes No

Explain your answer by referring to the level of risk stated in the TCPS definition:

The participants will be telling stories of their nursing education and early nursing careers in the 1960s and early 1970s in western Canada, specifically, in Calgary and Vancouver. The effects of the interview could be expected to be no greater than describing their experience to friends and colleagues. It is hoped that some introspection and thoughtful reflection will take place on the part of the participants and this too could be no more than would occur in their everyday lives. The consent form will also state that participants have the right to refuse to answer any questions or address any topics that they do not wish to or that they do not feel comfortable answering or discussing.

F. [Scholarly Review](#)

What type of scholarly review has this research project undergone?

- External Peer Review (e.g. granting agency)
 Supervisory Committee or Supervisor—required for all student research projects
 None
 Other, please explain:

G. [Other Approvals](#) and Consultations

Do you need to seek approval from other agencies, community groups, First Nations, local governments, etc?

Yes No

(Attach proof of having made request for permission or approval letter. Please forward approvals upon receiving them. Be assured that ethics approval may be granted prior to receipt of external approvals.)

If Yes, what types of other approval will you need?

- School District, Superintendent, Principal, Teacher
 VIHA or other regional government authority.
 Community Group (e.g., formal organization, informal collective)
 Indigenous Organization (e.g., Treaty Group, Tribal Council)
 Indigenous Community

Approval from an Indigenous community or organization may be required when the research involves Indigenous people in relation to their community or organizational affiliation (whether residing in urban or reserve areas), the cultural knowledge and/or resources of Indigenous people, or where individuals speak on behalf of an Indigenous community or nation.

a. Does your research specifically involve or include in the study’s population sample individuals from an Indigenous community or organization?

Yes No

b. Will a particular Indigenous community, group of communities, or organization be a central focus of the research?

Yes No

c. Will the cultural knowledge, resources or heritage of an Indigenous community be a central focus of the research?

Yes No

d. If you answered “yes” to questions a), b), or c) have you consulted with the Indigenous community or communities for this study?

Yes No

e. If you answered “yes” to question d), describe the process that you have followed or will follow. Include any documentation of consultations and the role or position of those consulted, including their names if appropriate.

f. If you answered “no” to question c), briefly justify your decision not to seek Indigenous community approval.

UVic Biosafety Committee Approval. Please attach Biosafety Human Materials Form to this application. Note that Ethics Approval is contingent on Biosafety Approval.

Other Approval, please explain:

H. [Description of Research Project](#)

1. Purpose and Rationale of Research

Briefly describe in non-technical language:

Please use 150 words or less. The form will expand to the length of your answers.

1a. The research objective(s) and question(s)

This program of research will contribute to a greater understanding of the significant intersections between the history of nursing, women, work and motherhood as reflected in changes in the social construction of nursing during the period 1958-1977. This inquiry will be contextualized through references to the post-war period and the decade following the 1960s and will build on scholarship in the areas of history, women's studies and nursing, including my own scholarship around the history of motherhood in post-war Canada.

Central Research Questions

Related to Archival and Secondary Sources:

1. What are the significant intersections between the history of nursing, women, work and motherhood in Western Canada during the 1960s and early 1970s as exemplified in changes in the social construction of nursing during that time period?

Related to Oral History Interviews:

2. How did women who became nurses, married, and became mothers experience changes in the social construction of women's roles during the 1960s and early 1970s particularly in Calgary Alberta and Vancouver British Columbia?
3. What were the major debates in feminism in Canada during the 1960s and early 1970s and are these debates reflected in the choices and considerations nurses made in regard to work, marriage and motherhood during this time period in Calgary and Vancouver?

1b. The importance and contributions of the research:

Women who came of age during the 1960s and early 1970s make up the majority of nurses, nurse educators and nurse leaders today in Canada and the US. Many will retire in the next ten years and be among the first group of professional women to have experienced a lifelong career outside the traditional gendered roles of wife and mother and to receive full work related pensions. Nursing is a complex social role in that nurses give care, and are socially and monetarily rewarded for that role, but in taking up a paid caregiving role, as women, they have simultaneously been accused of neglecting their more traditional roles as wife and mother. Nursing thus has a relationship to caring that demonstrates both a history of participation in and resistance to shifting gendered norms. According to the literature, this history has implications for explaining and creating a greater understanding how past events have shaped the choices and opportunities available to some Canadian women today.

1c. If applicable, provide background information or details that will enable the HREB to understand the context of the study when reviewing the application.

The interviews will be supplemented by relevant secondary and archival sources.

I. [Recruitment](#)

2. Recruitment and Selection of Participants

2a. Briefly describe the target population(s) for recruitment. Ensure that all participant groups are identified (*e.g. group 1 - teachers, group 2 - administrators, group 3 - parents*).

Purposeful and snow ball sampling will be used to recruit participants. In order to ensure a nuanced interpretation of the population of women who obtained their nursing education, married and had children during this time period, it is important to include diversity in terms of the demographic profile of the participants. This diversity will include race, ethnicity, gender, age, marital status, class and religious affiliation. Participants will be divided into six groups and will be chosen with consideration to this diversity:

Group 1: Those nurses who received their nursing education in Vancouver between 1958-1977 and continued to work in nursing following marriage and/or motherhood (5 participants).

Group 2: Those nurses who received their nursing education in Vancouver between 1958-1977 and resigned from nursing following marriage and/or motherhood (5 participants).

Group 3: Those nurses who received their nursing education in Vancouver between 1958-1977 and who had periods of employment and unemployment in nursing following marriage and/or motherhood (5 participants).

Group 4: Those nurses who received their nursing education in Calgary between 1958-1977 and continued to work in nursing following marriage and/or motherhood (5 participants).

Group 5: Those nurses who received their nursing education in Calgary between 1958-1977 and resigned from nursing following marriage and/or motherhood (5 participants).

Group 6 : Those nurses who received their nursing education in Calgary between 1958-1977 and who had periods of employment and unemployment in nursing following marriage and/or motherhood (5 participants).

2b. Why is this population of interest?

According to Statistics Canada (2006), 87% of nurses are women. Feminist scholars and historians have most often theorized women's position within western society as one of oppression within dominant gendered hierarchies of power. In fact, nursing has often been identified by feminists as an exemplar of that gendered hierarchy in the workplace. A review of the literature reveals historical tensions between nursing and feminism where feminists and feminist historians sought to conceptualize nursing as a quintessential female ghetto (Valentine, 1996; Warsh, 2010). Conversely, some nursing historians and feminist historians have argued that nursing provided increased possibilities for female employment and in fact significantly advanced women's emancipation from traditional unpaid caregiving roles (Malka, 2008). The early second-wave feminist movement in the 1960s and early 1970s served to give voice to and galvanize debates between nursing and feminism. My review of the literature reveals that while some historians have studied the origin of these debates at the national level, primarily in the US (for example Malka, 2008; McPherson, 1996; and Reverby, 1987), little has been written about nursing and feminism in Canada, particularly the lived experience of nurses in western Canada or about the diversity of women who became nurses during this time period. There is also little that has compared the impact of feminism on nursing in western Canada in different regions of the west.

In relation to this gap in the literature, Vancouver and Calgary represent diversity in terms of geography and population, and I would argue that they also differed in terms of their political and social climate during the 1960s and early 1970s. Both however are urban centers that offered a variety of opportunities for women's education, including nursing education, and both had a population base that would allow for the diversity called for in my participant selection criteria.

2c. What is the desired number of participants?

Interviews will be held with approximately 30 participants.

2d. What are the salient characteristics of the participants (*e.g. age, gender, race, ethnicity, class, position, etc.*):

The salient characteristics of the participants will include diversity in terms of age, marital status, religion, gender, culture, ethnicity and class. These participants must be available for an in-person or phone interview and be able to communicate in English.

2e. Provide a detailed description of your exact recruitment process. Explain:

i) Who will recruit/contact participants (*e.g. researcher, assistant, third party*)

I will recruit and contact the participants.

ii) List and explain any relationship between the investigator(s) and participant(s) (*e.g. acquaintances, colleagues*). Complete item 3 if there is a [power over relationship](#) (*e.g. instructor-student, manager-employee*).

iii) Describe how recruitment will be done (*e.g. in person, by telephone, letter, snowball sampling, word of mouth, advertisement*) and from what source(s) will the participants be recruited. If applicable, include how contact information for participants will be obtained.

Recruitment will be done through purposeful and snowball sampling, using professional contacts and media venues. To ensure diversity, professional associations as well as public venues including newspapers, magazines, local historical publications, alumni organizations and nursing education institutions (including hospital schools of nursing) located in Vancouver and Calgary will be targeted through the Invitation to Participate recruitment letter (see Appendices).

iv) Describe the steps in the recruitment process.

I will create a recruitment letter that uses accessible and transparent language and outlines the research I am interested in conducting and asking if the individual is interested in participating in an in-person or telephone

audio-taped interview.

The recruitment letter will provide my contact information in the event that individuals are interested or have questions or concerns. The letter outlining the research will be e-mailed or mailed to potential participants and I will use the same project and recruitment information when contacting individuals by phone or in person.

v) Indicate whether the permission of other bodies is required for recruitment (*e.g. school boards*).

No

3. Power-Over

If you are completing this section, please refer to the:

Guidelines For Ethics in Dual-Role Research for Teachers and Other Practitioners

Are you or any of your co-researchers in any way in a position of authority or power over participants? Examples of a “power-over” situation include teachers-students, therapists-clients, supervisors-employees and possibly researcher-relative or researcher-close friend.

Yes No Varies

If *yes* or *varies*, describe below:

- i) The nature of the relationship.
- ii) Why it is necessary to conduct research with participants over whom you have power.
- iii) What safeguards (steps) will be taken to minimize inducement, coercion or potential harm.
- iv) How the dual-role relationship and the safeguards will be explained to potential participants.

Recruitment Materials Checklist:

Attach all documents referenced in this section (*check those that are appended*):

- Script(s) – in-person, telephone, 3rd party, e-mail, etc. –
- Invitation to participate (*e.g. Psychology Research Participation System Posting*)
- Advertisement, Poster, Flyer
- None; please explain why (*e.g. consent form used as invitation/recruitment guide*)

J. Data Collection Methods

4. **Data Collection**

For community-based research, autobiographical or observational research, please see Appendix III of the Guidelines.

4a. Which of the following methods will be used to collect data? *Check all that apply.*

<input checked="" type="checkbox"/> Interviewing participants: <input checked="" type="checkbox"/> in-person <input checked="" type="checkbox"/> by telephone <input type="checkbox"/> using web-based technology (explain) <input type="checkbox"/> Conducting group interviews or discussions (including focus groups)	<input checked="" type="checkbox"/> Attach draft interview questions
<input checked="" type="checkbox"/> Administering a questionnaire or survey: <input checked="" type="checkbox"/> In person <input checked="" type="checkbox"/> by telephone <input type="checkbox"/> mail back <input type="checkbox"/> email <input type="checkbox"/> web-based <input type="checkbox"/> Other, describe:	<input checked="" type="checkbox"/> Attach questionnaire or survey: <input type="checkbox"/> standardized (one with established reliability and validity) <input checked="" type="checkbox"/> non-standardized (one that is untested, adapted or open-ended)
<input type="checkbox"/> Administering a computerized task (<i>describe in 4b</i>)	
<input type="checkbox"/> Observing participants <i>[In 4b, describe who and what will be observed. Include where observations will take place.]</i>	
<input checked="" type="checkbox"/> Recording of participants using: <input checked="" type="checkbox"/> audio <input type="checkbox"/> video <input type="checkbox"/> photos or slides	<input type="checkbox"/> Images used for analysis <input type="checkbox"/> Images used in disseminating results <i>[include release to use participant images in consent materials]</i>
Analyzing secondary data or secondary use of data (Refers to information/data that was originally gathered for a purpose other than the proposed research and is now being considered for use in research., <i>e.g. patient or school</i>	

records, personal writings, lesson plans).

Secondary data involving anonymized information (Information/data is stripped of identifiers by another researcher or institution **before** being shared with the applicant). May be eligible for [Application for a Waiver from Full Ethical Review](#))

Secondary data with identifying information (Data contains names and other information that can be linked to individuals, *e.g.*, *student report cards, employment records, meeting minutes, personal writings*).

In item 4b describe the source of the data, and explain whether and how consent was obtained from the individuals for use of their data.

Using human samples (*e.g.*, *saliva, urine, blood, hair*)

*Ensure that you apply to the [Biosafety Committee](#) for the storage and use of biological materials. Also, complete the Human Materials Form, have it signed and attach it to your application. If using human tissue **only**, skip to 7g-8, 11-end.*

Other, specify:

- 4b. Provide a sequential description of the procedures/methods to be used in your research study. List all of the research instruments and interview/discussion questions, and in an appendix provide copies of all instruments. If not yet available, provide drafts or sample items/questions. For multi-method or other complex research, use the following sections in ways best suited to explain your project. If you have more than one participant group, be sure to explain which participant group(s) will be involved in which activity/activities.

This study would involve one 15 minute demographic questionnaire and one 75 minute audio-taped interview, totalling 90 minutes, at a time and location of participant's choice. I will request to record the conversation on a digital tape recorder. The participant is not obliged to answer or respond to any questions or topics that they are not comfortable with. There are no set questions for the interview, although some questions could include:

“What was your experience of becoming a nurse in western Canada in the 1960s and early 1970s and did your role as a woman at that time influence that experience?”

“How did your role as a woman influence your experience of being a nurse during this time period?”

“What other factors were significant in shaping your experience of being a nurse during this time period?”

“What meaning do you now make of being a nurse during this time period?”

“What questions about the experience of being a nursing during this time period have not been asked in this interview and that are important for me to know about?”

- 4c. Where will participation take place? (Provide specific location, *e.g.*, *UVic classroom, private residence, participant's workplace*)

In person at a place and time of the participants choosing if the participant lives within a reasonable distance for the researcher to travel. If this is not possible, or if the participant chooses, the interview will take place over the telephone at a convenient time for the participant.

- 4d. How much time will be required of participants?

15 minutes for the demographic questionnaire and 75 minutes for the audio-taped interview for a total of 90 minutes.

- 4e. Will participation take place during participants' office hours or instructional time? If so, indicate whether other permission (*e.g. from workplace supervisor*) is required.

No

Data Collection Methods Checklist:

Attach all documents referenced in this section (*check those that are appended*):

- Standardized Instrument(s)
 Survey(s), Questionnaire(s)
 Interview and/or Focus Group Questions
 Observation Tools

- K. Possible Inconveniences, Benefits, Risks and Harms to Participants

5. Benefits

Identify any potential or known benefits associated with participation and explain below.

Keep in mind that the anticipated benefits should outweigh any potential risks.

To the participant To society To state of knowledge

Participant:

The participant will have the opportunity to talk about the joys experienced and the challenges faced during their early nursing education and career. They will have the satisfaction of knowing that sharing their experiences will enhance society's understanding of the profession of nursing and the role of women in society – particularly in the post-war period in western Canada.

Society:

The education and professional standing of nurses is of primary importance to society. In a time of reduced numbers of nurses available to fill positions in nursing it is vital that more nurses are attracted to, educated in, and enter the profession. The role of nursing in today's Canadian context and the historical and social factors that have both challenged and promoted the profession reflect wider trends in women's work experience and social roles.

This study will contribute to a greater understanding of the role of women's labour, the impact of marriage and motherhood on women's labour, and the role of nursing in shaping current attitudes toward women's participation in the social and economic benefits of Canadian citizenship.

State of knowledge:

The outcome of this study would make a significant contribution not only to nursing history, but also to the history of women's labour, Canadian history and feminist history.

6. Inconveniences

Identify and describe any known or potential inconveniences to participants:

Consider all potential inconveniences, including time devoted to the research.

The time it takes to complete the 15 minute demographic questionnaire and the 75 minute audio-taped interview.

7. Estimate of Risks

Could this study involve the following? Please answer each question by putting an **X** in the appropriate boxes:

7a. Could a participant feel demeaned or embarrassed during their participation in the research?

Very unlikely Possibly Likely

7b. Could a participant feel fatigued or stressed due to the research?

Very unlikely Possibly Likely

7c. Could a participant experience any other emotional or psychological discomfort as a consequence of participation?

Very unlikely Possibly Likely

7d. Is there any social risk, possible stigmatization, loss of status, privacy and/or reputation?

Very unlikely Possibly Likely

7e. Are there any physical risks?

Very unlikely Possibly Likely

7f. Could a participant experience any economic risk? (e.g. job security, job loss)

Very unlikely Possibly Likely

7g. Do you see any chance that participants may be harmed in any other way? (e.g. risk to community)

Very unlikely Possibly Likely

8. Possible Risks

If you indicated in Item 7 (a) to (g) that any risks are *possible* or *likely*, please explain below:

8a. What are the risks?

8b. What will you do to try to minimize or prevent the risks?

8c. How will you respond if the risk of harm occurs? (e.g. *what is your plan?*)

9. Deception

Will participants be fully informed of everything that will be required of them prior to the start of the research session?

Yes No (If no, complete the [Request to Use Deception form](#) on the ORS website.)

L. Compensation

10. Compensation

10a. Is there any compensation for participating in the research (e.g. gifts, honorarium, bonus points, reimbursement for transportation, parking, childcare, etc.)?

Yes No

If yes, explain the nature of the compensation and why you consider it to be necessary:

Also consider if the amount of compensation could be considered to be a form of inducement.

10b. Explain what will happen to compensation if participants withdraw during or anytime after data collection (e.g. compensation will be pro-rated, full compensation will be given, etc.).

M. Free and Informed Consent

The following questions address the competence of participants to give consent, the process used in your research to obtain consent, ongoing consent, and the participants' right to withdraw. Consult Appendix V of the Guidelines for further information.

11. Participant's Capacity (Competence) to Provide Free and Informed Consent

Identify your prospective participants: (Check all that apply.)

Competent	Non-Competent
<input checked="" type="checkbox"/> Competent adults <input type="checkbox"/> A protected or vulnerable population (e.g., inmates, patients)	<input type="checkbox"/> Non-competent adults: <input type="checkbox"/> Consent of family/authorized representative will be obtained <input type="checkbox"/> Assent of the participant will be obtained
<input type="checkbox"/> Competent youth <input type="checkbox"/> Youth 13 to 18: consent of youth will be obtained, and parental consent is required due to institutional requirements (e.g. school districts) <input type="checkbox"/> Youth 13 to 16: consent of youth will be obtained, parents will be informed <input type="checkbox"/> Youth 13 to 16: consent of youth will be obtained, parents will NOT be informed <input type="checkbox"/> Youth 17 to 18: consent of youth will be obtained, parents will not be informed	<input type="checkbox"/> Non-competent youth: <input type="checkbox"/> Consent of parent/guardian <input type="checkbox"/> Assent of the youth will be obtained
<input type="checkbox"/> Competent children <input type="checkbox"/> Children under 13: consent of parent/guardian will be obtained, and child consent will be obtained <input type="checkbox"/> Other, explain:	<input type="checkbox"/> Non-competent children: <input type="checkbox"/> Consent of parent/guardian <input type="checkbox"/> Assent of the child will be obtained

12. Means of Obtaining Consent:

(Check all that apply, attach copies of all consent materials, complete item 13)

Signed consent. (Attach consent script(s) and consent form(s) - see [template](#) available on ORS Website) **Verbal** consent. (Attach information letter(s). Explain below why written consent is not appropriate and how verbal consent will be documented.)

Implied consent (e.g. anonymous, mail back or web-based survey. Attach information letter, see [template](#))

Other means. (Explain below and provide justification.)

Consent **will not be obtained**. (Please see [TCPS Article 2.1c](#) and explain below)

Explain consent procedure if "verbal consent," "other" or "consent will not be obtained":

13. Informed Consent

Describe the exact steps you will follow in the process of explaining and obtaining informed consent.

During the initial contact with the researcher the following information will be verbally presented and will also be forwarded to the potential participant along with written consent forms for both the 15 minute

demographic questionnaire and 75 minute interview. The consent form will be completed and returned to the researcher by either fax or mail.

Information to be verbally presented and provided in paper copy to the participant:

A full explanation of the objective of the study.

A full description of the methods of the study.

A discussion of the use of pseudonyms and other means to prevent identification.

A description of the methods to keep all data confidential.

Discussion regarding the use of the data in other research projects.

A description of the right to withdraw from the research at any time without explanation or recrimination, and a description of the use of the data should such withdrawal take place.

Participants will be asked to consent by signing the consent form for either the demographic questionnaire and/or the audio-taped interview and to return the form(s) to the researcher prior to the interview.

14. Ongoing Consent

Ongoing consent is required for research that occurs over multiple occasions and/or multiple research activities and/ or extended periods of time (i.e., more than one point of contact, including second interviews, review of transcripts, etc.)

14a. Will your research occur over multiple occasions or an extended period of time?

Yes No

14b. If yes, describe how you will obtain and document ongoing consent:

If an additional interview is required for clarification, consent will be revisited in the same manner as described above and another consent will be obtained.

15. Participant's Right to Withdraw

Free and informed consent requires that participants have the right to withdraw at any time without consequence or explanation.

Describe what participants will be told about their right to withdraw from the research at any time.

The consent form will address each participant's right to withdraw from the study at any time without explanation or consequences.

16. What will happen to a person's data if s/he withdraws part way through the study or after the data have been collected/submitted? If applicable, include information about visual data such as photos or videos.

It will not be used in the analysis and will be destroyed.

It is logistically impossible to remove individual participant data (*e.g. anonymously submitted data*).

When linked to group data (*e.g. focus group discussions*), it will be used in summarized form with no identifying information. Include this agreement in the consent form.

It will be used in the analysis if the participant agrees to this. Describe how this agreement will be obtained: **the participant's data will only be used if the participant provides written permission to do so.**

Free and Informed Consent Checklist:

Attach all documents referenced in this section (*check those that are appended*):

Consent Form(s) – Include forms for all participant groups and data gathering methods

Letter(s) of Information for Implied Consent

Verbal Consent Script

N. Anonymity and Confidentiality

17. Anonymity

Anonymity means that no one, including the principal investigator, is able to associate responses or other data with individual participants.

17a. Will the participants be anonymous in the data gathering phase of research?

Yes No

17b. Will the participants be anonymous in the dissemination of results (*be sure to consider use of video, photos*)?

Yes No

18. Confidentiality

Confidentiality means the protection of the person's identity (anonymity) and the protection, access, control and security of his or her data and personal information during the recruitment, data collection, reporting of findings, dissemination of data (if relevant) and after the study is completed (e.g., storage).

18a. Will the confidentiality of the participants and their data be protected?

No - If confidentiality will not be protected, explain why. If you are asking the participants to waive their right to confidentiality (you plan to identify them with their data), explain what steps will be taken to respect their privacy, if any.

Yes, completely

Yes, with limits (*Check relevant boxes below.*)

Limits due to the nature of group activities (*e.g. focus groups*) the researcher can not guarantee confidentiality

Limits due to context: The nature or size of the sample from which participants are drawn makes it possible to identify individual participants (*e.g. school principals in a small town*)

Limits due to selection: The procedures for recruiting or selecting participants may compromise the confidentiality of participants (*e.g. participants are identified or referred to the study by a person outside the research team*)

Limits due to legal requirements for reporting

Other:

18b. If confidentiality will be protected, describe the procedures to be used to ensure the anonymity of participants and for preserving the confidentiality of their data (*e.g. pseudonyms, changing identifying information and features, coding sheet, etc.*).

18c. If there are limits to confidentiality due to the methods (*e.g. group interview*), sample size or legal requirements (*e.g. reporting child abuse*) so that you cannot guarantee confidentiality, explain what the limits are and how you will address them with the participants:

As the nursing community in the 1960s and 1970s in Calgary and Vancouver may represent a limited population due to: the size of these cities during this time period; the number of institutions where women could obtain their education and employment; and the age of participants now, it may be possible for other participants and the public to identify who the participants are. Also, the nature of purposeful sampling and snow-ball sampling could mean that participants are known to each other or to the researcher. I will give each participant a pseudonym and I will not identify the specific location of the school from which the participant obtained their nursing education, nor their place of employment following graduation; however, the city – either Calgary or Vancouver will be named. The consent form will state that the confidentiality of the data will be preserved as much as possible under these circumstances by storing audio-tapes, any printed transcripts in a locked cabinet in the researcher's office, and typed information/transcripts in password protected files on the researcher's work computer. I will not link the information from the demographic questionnaire with the transcript of the audio-taped interview. Only the researcher will have access to the original data.

O. Use and Disposal of Data

19. Use(s) of Data

19a. What use(s) will be made of all forms of data collected (*field notes, photos, videos, audiotapes, transcripts, etc.*)?

The researcher will work on the production of an analysis and written text that addresses the study objectives. The interviews will be audio-taped with the participant's permission and later transcribed. A demographic questionnaire will be completed using an additional consent form. The researcher will keep field notes and a reflexive journal to document observations and thoughts that arise during the process and they will be used to inform the text. The resulting analysis of the data obtained from these interviews and the demographic questionnaire will serve as primary source data for the researcher's PhD dissertation and will be used along with other primary and secondary sources to inform the analysis of these sources.

19b. Will your research data be analyzed, now or in future, by yourself for purposes other than this research project?

Yes No Possibly

19c. If yes or possibly, how will you obtain consent for future data analysis from the participants (*e.g. request future use in current consent form*)?

This will be addressed in the consent form

19d. Will your research data be analyzed, now or in future, by other persons for purposes other than explained in this application?

Yes No Possibly

19e. If yes or possibly, by whom and how will you obtain consent from the participants for future data analysis by other researchers (*e.g. request future use in current consent form*)?

20. Commercial Purposes

20a. Do you anticipate that this research will be used for a commercial purpose?

Yes No

20b. If yes, explain how the data will be used for a commercial purpose:

20c. If yes, indicate if and how participants will benefit from commercialization.

21. Maintenance and Disposal of Data

Describe your plans for protecting data during the project, and for preserving, archiving, or destroying all the types of data associated with the research (*e.g. paper records, audio or visual recordings, electronic recordings, coded data*) after the research is completed:

21a. means of storing data (*e.g., a locked filing cabinet, password protected computer files*):

Data will be stored in locked filing cabinets and/or in password protected computer files.

21b. location of storing data:

The principal researcher has a private office with a personal computer and a locking filing cabinet. The data will be stored in that office, either in the locked filing cabinet and/or a password protected computer file.

21c. duration of data storage (if data will be kept indefinitely, explain):

The data will be kept for a period of seven years.

21d. methods of destroying or archiving data:

The data will be archived in the principal researcher's private office in a locked filing cabinet and/or a password protected computer file. Once the 7 year time limit has passed, all data will be destroyed by either shredding or permanent deletion from computer files.

22. Dissemination

How do you anticipate disseminating the research results? (*Check all that apply*)

Thesis/Dissertation/Class presentation

Presentations at scholarly meetings Published article, chapter or book

Internet Media (*e.g. newspaper, radio, TV*)

Directly to participants and/or groups involved. Indicate how (*e.g., report, executive summary, newsletter, information session*):

Other, explain:

P. Researchers

23. Conflict of Interest

23a. Apart from a declared dual-role relationship (Section I, item 3), are you or any of the research team members in a perceived, actual or potential conflict of interest regarding this research project (*e.g. partners in research, private interests in companies or other entities*)?

Yes No

23b. If yes, please provide details of the conflict and how you will manage it:

24. Researcher(s) Qualifications

In light of your research methods, the nature of the research and the characteristics of the participants, what training or qualifications do you and/or your research team have (*e.g. research methods course, language proficiency, committee expertise*)?

I am well versed with the methods of oral history and historical analysis and have just co-authored a chapter related to the use of oral history in nursing research this past year (Lewenson & Herrmann, 2008). My masters thesis, completed in 2003 used oral history interviews as the primary source material. In addition I have conducted oral history interviews with two separate ethics approved research projects through the School of Nursing at the University of Victoria in collaboration with experienced PhD qualified researchers. I completed my comprehensive exams successfully in September of this year and feel confident in my ability to conduct and analyse oral history interviews.

25. Risk to Researcher(s)

25a. Does this research study pose any risks to the researchers, assistants and data collectors?

No

25b. If there are any risks, explain the nature of the risks, how they will be minimized, and how they will be responded to if they occur.

Q. Further or Special Questions

26. Multiple Site Research

26a. Does this project involve collection of data at multiple sites within Canada requiring the approval of other sites, bodies or organizations (*e.g., other ethics board(s)*)?

Yes No

26b. If you responded Yes to 27a. above, list the sites, bodies or organizations:

27. International Research

27a. Will this study be conducted in a country other than Canada?

Yes No

27b. If yes, describe how the laws, customs and regulations of the host country will be addressed:

Appendix E: Sources

Primary Sources

Interviews

Thirty-seven oral history interviews

Archival

City of Calgary and Vancouver

- Records of Schools of Nursing (hospital, college, and university) in both cities related to educational standards and rules of conduct. These include regulations related to admission selection criteria including age, gender, marital status, class, ethnicity, and religion.
- Records of agencies hiring nurses in these cities, including hiring practices related to place of nursing education, age, gender, marital status, class, ethnicity, religion, and nursing experience.
- Records of professional organizations related to nursing, including provincial, national, and international bodies, as well as unions or other formal and informal organizations related to nursing education and employment.
- Information on the cost of living for women in these two cities, including housing options, wages, access to education and employment.
- Information on the status of women in these two cities, including demographics related to age, marital status, gender, class, ethnicity, religion, income, education, and occupation.

Province of Alberta and British Columbia

- Records of provincial regulating bodies related to women's employment, including

government hiring practices, private hiring practices, and hospital hiring practices.

Records of union organizations related to occupations where women were employed, including provincial nursing unions or work-related organizations.

- Records of provincial nursing organizations related to the education, regulation, and licensing of nurses—including criteria related to age, marital status, education, experience, ethnicity, and religion.
- Information on provincial government and private regulation of women's work, working conditions, and marital and reproductive status in relation to terms of employment in Alberta and British Columbia.

National Library and Archives Canada and Statistics Canada

- Information related to status of women reports, reports on women and education, women and employment, and specifically nursing education and employment, particularly those documents that contextualize changing attitudes toward women, marriage, work, and motherhood.
- Special government reports related to the impact of the Canada Health Act and health-related social welfare programs on the education and hiring of nurses.
- Canadian Nurses Association records related to attitudes, practices, and beliefs about nurses, education, and employment that contextualize changing attitudes toward married women in nursing.
- Records from organizations related to nursing and employment conditions and wages—the Canadian Union of Nurses or equivalent.

Popular media at the national or provincial level that characterize changing attitudes toward the roles of women in post-war Canadian society, with a focus on

employed women, married women, mothers, and nurses.