

MARY RICHMOND AND TRANSITIONS IN NURSING EDUCATION 1940-1990:
A BIOGRAPHICAL PERSPECTIVE

by

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Abstract

Nursing education in Canada, and more specifically British Columbia (BC) went through a significant period of transition post Second World War. The hospital based programs which began in the late 19th century started being phased out and move towards the college and university setting where nurses were educated in a manner similar to other professions. Mary L. Richmond, who was a graduate of a hospital based program at VGH in the 1940s, became a significant nursing leader in BC and played an influential part in the nursing profession during this time period.

This study takes a historical look, using the biographical method, at the transition of nursing education from hospital based programs to college and university programs. This transition is examined through the lived experience of Mary L. Richmond, a nursing leader and innovator during the transition period of the 1940s through to the 1990s. The findings of the study reveal the many social, cultural, economic and political influences that affected the movement of nursing education away from the hospital based model. The study reveals several themes influencing the transition including advancing technology, resource allocation, changing demographics, re-assignment of responsibility, and the shifting place of nursing education. In addition, the study provides a personal perspective overlying the changes that occurred, and reveals how Richmond emerged as a leader in bridging nursing education and practice. Many of the themes and issues arising from this study are similar to issues in nursing education and practice today. This study adds to the current research of the history of nursing education in BC and Canada and it provides a historical perspective from which to view and problem solve nursing education and practice issues in today's health care system.

Preface

This thesis is original, unpublished, independent work by the author S.L. Hlina.

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Dedication

I wish to dedicate this work to our past and present nursing leaders and specifically Mary L. Richmond. You have all provided a foundation and support for my place in the nursing profession.

Chapter One: Why Use a Historical Approach

Historical research is embarked upon to examine and illuminate how past events have influenced present behaviors and practices. If we can know what happened before then we can understand better the issues of today and hopefully gain insight into the future. Lewenson and Herrmann (2007) stated that history, historians, and methods of historical thinking are of value to the nursing profession because historical research enables nurses to explore their past and thus become critically aware of their professional identity and meaning.

There are several frameworks associated with historical inquiry including social, political, cultural, and biographical ones and they provide historians with a structure to question and interpret historical data. The purpose of my proposed study is to do a historical analysis and biography of Mary Richmond using historical methods to examine her nursing career thus informing my analysis of the transitions of nursing education during the post Second World War era examining the larger social, economic, and political changes influencing nursing education in British Columbia (BC) at the time. Through this historical analysis I hope to shed some light onto the contemporary issues of nursing education.

Study Purpose

Nursing education in Canada and specifically BC has gone through several periods of reform in the last 130 years. The establishment of university nursing education in 1919 in Canada and through the first half of the 20th century was “fueled by nurse’s discontent with the lack of higher educational opportunities and by the struggle of women to achieve social equality” (Baumgart & Kirkwood, 1990, p. 515). Nursing education was initially incorporated into the universities not because of a need to develop nursing scholarship but to improve the care provided to the sick. Around the turn of the 20th century acceptance of “the germ theory” and the

rise in infectious diseases saw a rapid growth in the public health movement. “Strong support for the move in BC to university preparation for nurses came from doctors associated with the public health movement. This support as well as many other factors contributed to the demands in BC for a university based nursing education program” (Zilm & Warbineck, 1994, p. 19). It is these other subsequent factors and influences on nursing education that I discuss in this thesis. Examining the significant change in Canadian nursing education through the lived experience of nurses and nurse leaders enhances our understanding of the culture and transitions in nursing education.

The questions that plagued nursing educators and hospital administrators during the second half of the 20th century still influence similar contemporary questions of today and influences how nursing education is delivered. Most notably, how should nursing education be structured? The first Canadian schools of nursing were based on the British “Nightingale model” where the school had considerable autonomy and was supported by donors from outside of hospitals. While the Nightingale model was the ideal at the onset of formal nursing education in Canada, the Canadian system soon became greatly influenced by the Schools of Nursing in the United States of America (USA). The training schools in Canada soon moved towards the increasingly popular hospital based model. “Hospital administrators quickly recognized the economic potential of student labour and, as a result, the hospital school of nursing model rapidly proliferated across Canada” (Bramadat & Chalmers, 1989, p. 720). Despite the popularity of hospital schools of nursing the lack of standardization that existed between hospital programs was considered problematic for nursing service and leadership. The third model which moved to raise the standards of the current hospital based programs was the academic model. Both first and second model were hospital based but time in the classroom was the key

difference between the two models. Examining why and what influenced the shift to the third model, baccalaureate education, as well as Mary Richmond's influence on this shift in nursing education is the focus of my research.

Background of Mary Richmond

In nursing research, biographical nursing histories have typically focused on women whose influence was of national proportions, such as Ethel Johns and Edith Kathleen Russell. Historians of nursing are now promoting examination of nurses' careers from women of diverse backgrounds and examining the relationships among gender, ethics, technology, community, and health (Grypma, 2007). By evaluating the changes that occurred in nursing education in the post war years through the work and experiences of Mary Richmond I hope to show not only Richmond's individual contributions but also the relationships occurring between gender, technology, politics, and education.

Mary Richmond was born in 1920 in Vancouver, BC. She graduated from Vancouver General Hospital (VGH) in 1943 and received her Bachelor of Science in Nursing from McGill University and her Master's degree from Columbia University. Her nursing career spanned more than 50 years and included such appointments as: director of nursing at Royal Jubilee Hospital (RJH); chairperson of the committee on nursing education with the Registered Nurses Association of British Columbia (RNABC); director of nursing at VGH; member of the committee which brought together the Council of Hospitals and Schools of Nursing in BC; director of educational resources at RJH; and in the final years of her career, acting director of nursing at the University of Victoria (UVIC) (Mary Richmond Fonds, BCHoNS). (See timeline of Mary Richmond's life in Appendix B).

Mary Richmond graduated from high school during the depression (1937); she was not able to afford to go to university at the time and as a result started volunteering with the Canadian Youth Congress. After obtaining her nursing diploma from VGH in 1943 her first job was working as a general duty nurse at Vancouver General Hospital. Her interest in education and teaching was evident early on in her nursing career as she moved across the country to obtain her diploma in teaching and supervision from McGill University in 1945. She moved back to the west coast of Canada and began teaching in the VGH nursing diploma program. Prior to becoming the director of Nursing Education at Royal Jubilee Hospital in 1951, Richmond returned to McGill to obtain her diploma in nursing administration and her BSN. In 1955 Richmond obtained her MA from Columbia University and then moved on to become the director of Nursing at RJH from 1956-60. From 1960-64 she was an assistant professor in the School for Graduate Nurses at McGill University. In 1964 Mary Richmond returned to Vancouver and was the director of nursing at VGH from 1964-1973. In 1974 she returned to the Royal Jubilee after being offered a new and exciting position as the Director of Educational Resources. The University of Victoria's school of nursing obtained approval to offer a baccalaureate degree program to nurses already holding RN registration in 1974 and Mary Richmond became an adjunct professor in the new program from 1976-1982, then a visiting professor from 1982-88; and from 1991-1992 she was the acting director of the School of Nursing at UVIC. She retired from Nursing in 1992 but continued to be a strong supporter of health care, nursing and nursing education.

Mary Richmond was a well-respected nurse and contributor to the growth and transformation of nursing education in BC. She was awarded many honours over the years and university bursaries have also been created in her name. One such award came from across the

world when she was awarded the Dr. D.P. Kennedy travelling fellowship from the New Zealand Nurses Association. In 1974 she travelled to New Zealand after being awarded the Dr. D. P. Kennedy travelling fellowship. Mary Richmond spent her time in New Zealand travelling around the country talking with nurses, administrators and educators on the many aspects of transforming nursing education from a hospital based program to one included in the university education system. She also spoke on the many aspects of the changeover, including the maintenance of nursing service during the transition period. On a personal level Mary Richmond had a great love of nature, never missed a day of walking her 5 miles and was an ardent supporter of the environment even going so far as to purchase an acre of the Brazilian rainforest. She was well loved by her friends and family who always called her “our Mary”. She died in 2002 at the age of 82.

Mary Richmond made several contributions to nursing education in BC from 1943 until she retired in 1992. She possessed several of the same qualities, intellect, and determination as nurses who played key roles in nursing history such as Jean Gunn, Ethel Johns, and Kathleen Russell. Richmond’s contributions to nursing and nursing education were significant in BC and occurred “at a time when patriarchal structures devalued the contribution of women” (Grypma, 2007, p. 65). My choice of focusing on Mary Richmond will show a unique focal point for the examination of nursing education in BC and add to the current historiography of nursing education post Second World War in Canada.

I chose the works of Mary Richmond as my focus for this research after a visit to the BC History of Nursing Society archives at the University of British Columbia (UBC) during my History of Nursing and Health Care course in the fall of 2012. Mary Richmond was an insightful individual who reflected on the state and development of nursing education in BC and

documented her thoughts about the future of nursing education; her contributions and stories sparked my interest. The BC History of Nursing archives hold a valuable collection of primary source material on Mary Richmond and provided me with an opportunity to examine the transition of nursing education post Second World War through an examination of her nursing career and work experiences.

Mary Richmond believed that better nursing care resulted from better nursing education. “The task of nursing education is to prepare people for a largely unknowable future, because even without major upheavals the health needs of our people change and education programs must respond” (Richmond, 1958). Richmond’s positions within the Registered Nurses Association of British Columbia, Vancouver General Hospital, and Royal Jubilee Hospital allowed her to express her views and make her voice heard with regards to nursing education issues. There were significant trends occurring between 1940 to 1990 which included technological advancements in medicine and nursing practice, changes in employment patterns, the “fractionalization” of nursing care, changes in disease patterns, and the shift and expansion of the nurse’s role. Richmond’s question to several organizations at the time was “What do we wish to teach nurses to do, to function efficiently in the large hospital, the small hospital, or to have a basic understanding which will enable them to adjust to varying situations” (Richmond, 1958). These trends influenced nursing education as did nurse leaders such as Mary Richmond.

Contextual Historical Research Literature

There are several key studies that will inform my historical analysis of nursing education transformation. First, Simpson and Abbott (2010) initially conceptualized their book *Traditions and Transitions*, to be a reference and a keepsake for all readers; it is an overview of the history of nursing education at Thompson Rivers University (TRU) from 1973 to 2003. The authors

include information not only about the program and its transitions but also information on the health and welfare of the Kamloops population in order to bring a greater understanding of how events and trends occurring in the Kamloops community had an effect on the School of Nursing and the changes it was making. The authors also include what was occurring at the time provincially as well as national and international perspectives. It is an impressive body of work and as an alumnus of TRU I feel it is an important piece of work that shows the history of nursing education in Kamloops and the work and dedication required to transform it over the years into a well-respected nursing education institution. *Traditions and Transitions* provide the reader with stories and historical accounts of the individuals involved in transforming the TRU School of nursing over the years. This structure shows how nursing leaders can have remarkable influence on an educational program; I endeavour to similarly show Mary Richmond's influence on nursing education in BC.

Second, Ross-Kerr and McPhail (1999) have several chapters in *Canadian Nursing: Issues and Perspectives* that will inform my work. The first one being Ross-Kerr (1999) *The Origins of Nursing Education in Canada: The Emergence and Growth of Diploma Programs*. This chapter gives a historical account of the earliest nursing schools in Canada, which were formed in conjunction with hospitals and discusses the movement towards improving standards of care in hospitals by transitioning the staffing of hospitals from nursing students to graduate nurses. It describes the emergence of diploma schools of nursing as freestanding institutions administered by separate boards of directors from the hospital. It concludes by segwaying into the next change in nursing education which is the transition from diploma to university level education as a result of the changing ideas around standards of education and nurse's responsibility for safe client care.

The next chapter in *Canadian Nursing: Issues and Perspectives* is chapter 22, *A historical approach to the evolution of university nursing education in Canada*, Ross-Kerr (1999). This chapter discusses the emergence of university schools of nursing across Canada and how societal changes such as the Depression and Second World War influenced university nursing education over the years. Financial funding played a large role in shaping how nursing education was delivered. Across the country some schools were on the brink of termination while others received decades of support from financial backers outside the country such as the Rockefeller Foundation. After the Second World War the oversupply of nurses triggered by the Great Depression became a shortage as hospital care expanded and demand for better prepared nurses grew. Funding issues arose for schools of nursing and became a prominent point as federal interest in higher education grew and university schools of nursing reaped the benefits. With the increasing number of university nursing education programs across the country it was clear that an overall look at the programs and ways to improve them were needed. This launched the *Pilot Project for the Evaluation of Schools of Nursing* study through the Canadian Nurses Association (CNA), Mussallem (1960).

The final chapter in Ross-Kerr and McPhail (1999) *Canadian Nursing: Issues and Perspectives* that will influence my work is *Entry to Practice: Striving for the Baccalaureate Standard* (Wood, 1999). Minimum entry to practice requirements has been a controversial and hotly debated topic in the nursing profession. Wood's (1999) chapter gives a historical account of how entry to practice requirements changed over the years. Wood (1999) described trends and issues that influenced transitions in nursing education over time. These include changes in Canadian communities, health care technology, the health issues and needs of the population, and the changes and expectations of how nurses interact and provide care to individuals,

families, and communities. Wood's chapter will form a key piece of research that informs my work as I also examine the trends in nursing, nursing education and society that were influential during Mary Richmond's career.

The third source of information I will draw on is *Faculty of Nursing on the Move* (Boschma, 2005). In this monograph Boschma (2005) provides a historical account of the creation and development of the school of nursing at the University of Calgary, including the faculty. The historical account of the thirty five years of the University of Calgary School of nursing shows us parallels and trends occurring during the specific time period of 1969-2004 and how those trends influenced the decisions and actions regarding nursing education. It shows how nursing leaders had to make continual changes over time in order to keep growing, to be relevant, and to improve standards of nursing care to maximize positive health outcomes.

Fourth, Florence Melchior wrote her doctoral dissertation in 2004 titled, *Nursing student labour, education, and patient care at the Medicine Hat General Hospital in Alberta 1890-1930*. This valuable historical analysis examines the belief and assumption that hospitals were staffed with nursing students because it was the most financially viable option for hospital boards. Melchior concludes that student staffing is more about the exploitive and oppressive powers exerted over malleable and submissive students and is tied to gendered notions of ethnicity, class and professionalism. Melchior strives to give suggestions for future directions in nursing education, to give a greater understanding of nursing history, and to add to existing historiography on women's work and waged labour (Melchior, 2004).

A final source of current research is *Prepared to Care* by Ross-Kerr (1998). This volume looks at the evolution of nursing in the province of Alberta. Her identification of themes and factors that influenced the development of the nursing profession will be a key piece of

historiography that will inform my own biographical historical perspective as it looks at the social, economic and political forces influencing change in the nursing profession in Alberta over its 137 year history. Ross-Kerr (1998) examined nursing education from its roots as a diploma program to its development in the university setting. In addition to providing a history of nursing in Alberta, Ross-Kerr presents a perspective on the meaning of nurses' work, how it relates to societal changes, and the status of women in society.

There are many other sources of research that will inform my historical analysis and that I will expand upon in further chapters. Three important sources are: The Weir report (1932) *On the Status of Nursing Education in Canada*, *History of nursing education at the University of British Columbia*, Zilm and Warbinek (1994) and *Spotlight on Nursing Education* authored by Helen Mussallem (1960).

Research Questions

The question about how to best prepare nurses for practice remains a current issue in nursing education. Eggertson (2013) for example, explored the disconnect between practice and education underscoring that the issues and questions occurring post Second World War with regards to nursing education are still relevant and worth exploring in today's nursing culture.

The history of nursing education is an important way to frame and investigate how nursing's past has and can influence its future direction. Historical research helps to raise new questions to inform our nursing education and practice. As Lewenson (2007) claims, "Historians study history to explain what happened in the past, by examining history, specifically nursing history it can lead to and support better decision making in health care and serve as a new paradigm for nursing knowledge" (p. 25).

The issue of how to best structure nursing education remains; are the new graduate nurses of today prepared for the realities of nursing practice? Some of the literature shows that the move towards a baccalaureate degree as an entry to practice requirement is essential as it “gives the highest probability of a practitioner coming with an understanding of the broad scope of the context of the health care system, the complex needs of the patient within that system, and the practice required to meet those needs” (Griffiths, 2000, p. 21). It is important to explore if the emphasis on baccalaureate education for registered nurses has provided solutions to the demand for better education for nurses or if to some degree it has also complicated the question of how best to educate nurses.

The goal of my historical research study is to interpret meanings of the social, cultural and political influences on the development of nursing education post Second World War through the work and experiences of Mary Richmond who was a leader in nursing practice and education in BC during this time period. This examination will shed light on the current and future education of nurses and raise questions about how the current education system is meeting the needs of our health care system. My examination of nursing education in BC captured within a biographical framework will provide a unique personal perspective and context to the transition of nursing education post Second World War as seen through the nursing career of Mary Richmond. The questions I will explore in my thesis include:

1. What social, cultural, economic and political issues and themes were occurring in BC from 1940-1990 that influenced nursing education transitions from hospital based programs to universities? Was it reflective of what was happening in the rest of Canada?

2. How did Mary Richmond's leadership positions and privileged status shape her views on nursing education?
3. How did Mary Richmond and her contemporaries perceive the impact of the shift of nursing education from the hospital based programs to the universities on the preparedness of nurses and on patient care?

Limitations of Historical Research

Although the biographical method of historical nursing research is an important way to expose nurses and nursing history to the general public there are limitations to this form of research. Grypma (2008) noted that dealing with a lack of primary sources can lead to a limitation of perspectives; without sufficient evidence the subject can become lost in the background of events, actions and circumstances. When using the biographical method of research it becomes vital to ask the right questions and to stay away from simply describing the events of the subject's life; it is essential as the researcher to immerse oneself into the subject's life and focus on how they responded to the events around them.

Summary

The post Second World War period was a significant time in the evolution of nursing education as hospital schools of nursing were closing and the education of nurses was moving to the university setting. The trends occurring in nursing during this time were not isolated but reflected changes that were occurring in society and more specifically changes in medical practices, advancing technology and the attitudes and expectations of society with regards to their health care and to women's roles.

I will be exploring the social, economic and political influences on the transition of nursing education from the hospital to universities during this time period. I will be exploring

this question using a biographical framework, examining the historical perspectives through the life and works of Mary Richmond who was an important contributor to nursing education in BC during this period.

Chapter Two: Framework and Methodology

Frameworks provide historians with a structure to question and interpret historical data. “While they help to guide inquiry, they are neither rigid nor static. Rather, as we see in the history of history, the relationship among frameworks, data, and the questions asked are reciprocal and dynamic, with each influencing the other” (Buck, 2007, p. 59). I will be using a biographical framework to guide my inquiry. The coalescing of biographical and history of education frameworks grounded in social history approaches will provide a rich and encompassing guide to my research. Just as biographical historiography is moving towards examining themes, “social history provides an inclusive framework for reinterpreting the past experiences of ordinary people, movements, and events through the thematic prisms of class, gender, and race” (Buck, 2007, p. 46).

With the biographical framework as my guide I will be examining the social influences on the transitioning of nursing education from hospital nursing schools to schools of nursing within the university setting in post Second World War BC. To achieve this goal, I will be drawing on the work and experiences of Mary Richmond. Using a combination of frameworks allows me to uncover themes and relationships occurring in nursing education as well as being able to view the larger context through the experience of one individual.

Research Design

Historiography is the framework for engaging in historical research. While historians may not follow a specific set of methodological process there are “stages” through which most historical research passes. These stages include choosing a topic and appropriate framework; finding and accessing the sources; and analyzing, synthesizing, interpreting, and reporting the

data (Lusk, 1997, p. 355). By examining past data on nursing education transitions post Second World War I can interpret the changing context of nursing education programs.

To begin a historical study, it is essential to identify an area of interest. I will be conducting historical research, more specifically a biography of an influential nursing leader in nursing education in post war BC. My area of interest is nursing education transitions from 1940-1990 in BC as seen through the works and experiences of Mary Richmond. My historical analysis will follow a chronological path. I will begin with looking at Richmond's formative years in education from 1941-1956, this will follow by examining her years of work as a director of nursing and nursing education at both VGH and RJH from 1951-1982. This will follow with an examination of her work and experiences as a nursing educator from 1974-1992 and finally a discussion of her work, contributions and positions she held with many nursing organizations and committees over the course of her career.

The intent of using biographical methodology in nursing history is to assist us in interpreting the meaning of certain time periods, issues or phenomena through the experiences of an individual. Grypma (2008) indicates four critical issues in the use of biographic methods in nursing history that need to be addressed when using this type of methodology. The first issue is addressing worthiness in subject selection. Grypma (2008) alludes to the difficult issue of determining worthiness of subjects, but if historians are to show a balanced view of nursing history then it is essential to include not only nursing's elite but illuminate the lives of previously unknown nurses as well. By exploring Mary Richmond's nursing career I will contribute a richer understanding of the transitions taking place in BC nursing education history.

Choosing a "worthy" subject is only the beginning of the process of historical biography. It is also essential to ensure there are adequate sources available on the subject. While the

primary sources I have obtained from the archives at UBC, CRNBC and UVIC are not exhaustive of all aspects of Mary Richmond's life and nursing career, I believe they are sufficient to keep her in the foreground of my research. Ensuring that adequate and accurate sourced material is available is also essential in order to provide readers with a clear understanding of how the subject responded to events rather than just the events themselves (Grypma 2008, p. 69).

The third critical issue in the use of the biographic method in nursing history is to exemplify the truth in data analysis. Grypma (2008) contends that "truth" in the biographical method refers to accuracy and reliability of a study and the challenge is to produce a true portrait of a nursing subject. By examining Richmond's nursing career and her place within the sphere of nursing education I endeavor to not give a recitation of her day to day life and accomplishments but to discover the meaning of the decisions and contributions she made to nursing education in BC; in essence, what made her unique? As I attempt to address the truth in data analysis I will also examine what was happening in the nursing profession post Second World War as this provides context for the biography.

The fourth and final critical issue is writing a compelling report. I shall endeavour to hold the readers interest by following Grypma's (2008) five recommendations for writing a compelling biography. They include, leaving the reader with an impression of a major resonating theme; concentrating on quality not quantity; being explicit about assumptions and distinguishing my voice from that of the subject; bringing the subject to life; and giving credit to sources using footnoting.

Sources

There are two types of data in historical research, primary sources and secondary sources. “A primary source is first-hand information such as original documents, relics, or artifacts authored directly by people involved in the event; secondary sources are second or third-hand accounts of historical events or experiences written by individuals who did not participate in the event” (Polit & Beck, 2012, p. 501). Historical research is not about selecting a sample to study and research but rather to explore, examine, and evaluate what data is available on a particular subject or person of interest. It is rare in historiography that a plethora of data is readily available, therefore my research “sample” will include all data that is practically accessible. The majority of data I hope to collect will be primary source material, mostly documents including letters, meeting minutes, speeches, and other personal correspondence of Mary Richmond. Currently I have collected primary source material from the BC History of Nursing archives at UBC, from the CRNBC library in Vancouver, and from the archives at UVIC. They include taped interviews with Mary Richmond that were a part of the Oral History Project at the RNABC (1987), and an interview with Mary Richmond conducted by a member of the history of nursing biographical committee of RNABC in 1993. From UBC I have obtained several textual records including transcripts of lectures given by Mary Richmond at Royal Jubilee Hospital, UVIC school of Nursing, and VGH. As well I have newspaper clippings from her months spent in New Zealand on an educational fellowship grant, and many other talks, lectures and speeches she gave on nursing education and practice during her career. Included in the archived material are also photographs of her nursing classes as well as pictures of the awards that were bestowed upon her. Furthermore, I will include relevant published material in reports and nursing journals, including the Canadian Nurse and Nursing BC.

Unlike interviews and observational episodes, documents exist before the researcher seeks to use them as data. Miller and Alvarado (2005) state, “researchers who use documents address their distinctive features in three main ways through: (a) strategies of document selection, (b) consideration of the social exchange of documents and, (c) consideration of the socially produced nature of documents i.e. source criticism” (p. 349). There are three ways of selecting documents for research: representative or random sampling; purposive sampling; and purposeful but non-sampling selection. I will be using purposive sampling, selecting all available primary sourced documents that will benefit my study. I examine educational transitions during a specific time period and through the experiences of a particular person, therefore I am looking for primary sources of data on Mary Richmond dealing with the changes in nursing education from 1940-1990 and also looking for secondary sources with my specific criteria that provide historical context for my biography of Mary Richmond. It is my goal to select the most appropriate sources of data relating to the goals of my research.

Even though I am collecting all primary sourced material available to me, I must be conscious that “the availability of the documents is embedded in social processes based on the decisions of many individuals and institutions to preserve or allow access” (Miller & Alvarado, 2005, p. 350). It is important as a historian to remember that primary source documents will always be incomplete and have a sense of uncertainty about them. Keeping this in mind the historian and biographer must closely evaluate what the data/document is and is not telling them. I am aware that my own biases may come into play when selecting sources. Critical questions in this regard include: am I more inclined to select primary and secondary sources from one particular archive over another because of the ease of use, availability, or less financial strain to myself in accessing them? Although I need to be aware of my biases it will be of the greatest

importance due to the paucity of data on this issue to include all sources and interpret and evaluate what the data is or is not able to tell me.

Data Collection

Data collection begins by reviewing the literature and reading, which is the first part of a historian's methodology. D'Antonio (2007) stated that as a historian one reads to discover what is known, contested and yet to be discovered. Examination of the literature places Mary Richmond's experiences within the biographical framework of historical inquiry and is a way to understand the transition of nursing education from 1940 to 1990 in BC. Reading also allows the historian to learn how to organize data, structure arguments, address significance, and draw conclusions.

Having obtained all current material on Mary Richmond from the archives at UBC, UVIC and CRNBC, I continued to search for primary source material at other institutions Richmond worked at and contributed to including the Canadian Nurses Association, VGH and RJH. I also determined if there were any available primary or secondary sources online. I contacted LeAnn Bryant the UBC librarian for assistance in narrowing my search focus using terms such as education, nursing, reform, transition, Mary Richmond, and setting limits in terms of the particular time period I was interested in. Lee Ann has also been instrumental in assisting to locate certain documents such as the Weir Report that I was unable to find on my own. I drew on Lee Ann Bryant's knowledge and assistance to determine if there were archived materials available at the different institutions Mary Richmond belonged to during her nursing career and made several trips to the lower mainland to examine and retrieve the documents housed in the archives. I copied the material and brought it back home for further analysis. There are several limitations that affect the historical researcher's ability to locate data and I took these into

consideration when conducting my data collection. First, there can be access restrictions to certain archives; historical material may have been discarded or is not accurately indexed. Identifying appropriate material took a considerable amount of time and due to the fact that I live outside of the Lower Mainland, where the archives exist, there were financial issues and limitations that I considered as well.

Data Analysis

When interpreting data in historical research it is important be aware of the contingencies that are occurring. Lewenson (2007) gives several examples including conflicting stories, missing pieces, personal and professional bias and ideology, and various organizing frameworks. Organizing the sources within the biographical framework enabled me to see the connections between Mary Richmond and the larger context of nursing and nursing education in BC. Accuracy in historical research is embedded in the processes of external and internal criticism. “External criticism questions whether a document is authentic. The paper, ink, dates, and writing or typing is some of the details that must be verified, this may require expert advice from researchers in several disciplines” (Lusk, 1997, p. 358). Although it is normally assumed that documents held in reputable archives are authentic there are several recommended ways of uncovering historical fraud. I can look at related documents to compare their style and content as well as examining different versions of the original document and after reading the document making a judgment about whether it makes sense or if there are any obvious errors. “Internal criticism determines the reliability of the document and addresses the question of credibility. Subsumed under this type of criticism are the classifications of positive and negative criticism” (Sarnecky, 1990, p. 4). As the researcher using positive and negative criticism it is essential to understand the content of the evidence and evaluate the accuracy of the statements made in the

evidence. In order to accurately analyze the primary source data I collect I needed to understand the meaning of what Mary Richmond was saying. Being able to determine her motives and biases about the documents she wrote is my goal by finding corroborative evidence and seeking out multiple sources on the same issue.

Miller and Alvarado (2005) discuss three ways to analyse documents: the analysis of documents for their content (content analytic); the analysis of documents as commentary (context analytic); and the analysis of documents as actors (context analytic). In using the documents as commentary I endeavored to provide insight into meanings, the actions of individuals and communities and to attempt to interpret what was occurring within the social context during the time of nursing reform post Second World War.

I believe the most important aspect of historical data analysis is finding meaning from the data, examining and comparing the relationships, identifying themes, and then interpreting those meanings. Some themes that have already emerged through my examination of primary source material include, technological changes, societies changing health care needs, holistic nursing care, interdisciplinary working relationships, leadership, women's work, and nursing research. In what follows I further explore the relationships between these themes. To support my analysis and interpretation I kept a detailed record of the research I found, where I found it, who assisted me, and how long it took to find. I also kept a journal with all the important information in order to keep organized as well as to provide me with an outlet for the self-reflection which is integral to the historical research process.

Ethical Considerations

It is important in historical research to address ethical issues before, during and after the research study. The following principles drawn from Birnbach (2007) guided my research:

- Historians have the responsibility to their sources to accurately report all information relevant to the subject.
- Historians have the responsibility to subjects to present historical truths insofar as they can be determined from available sources.
- Historians share knowledge and experience with other historians through professional activities and assist the professional growth of others with less training or experience.
- Historians serve as advocates to protect historical resources.
- Historians are dedicated to truth. Flagrant manifestations of prejudice, distortions of data or the use of deliberately misleading interpretations are abuses inconsistent with professional responsibility.
- Historians promote the development of historical databases.
- Historians advocate for the integration of historical research into the broader field of nursing inquiry.
- Historians demonstrate sensitivity in the use of confidential information and utilize appropriate historical research methodology.

It is important to also avoid injuring the reputation of others, removing archival material without authorization and damaging historic documents. Moving forward it's important to keep in mind several issues. I must know why I am doing the study, make fair judgements, and be true to the data. This comes through journaling, self-reflection, and knowing my biases. Having nurse historians on my committee is an essential aspect of "knowing what data needs to be included in order to be truthful to the data and respectful of the subjects" (Lewenson & Herrmann, 2007, p. 179).

Summary

Included in this chapter is an explanation of the framework I used for my research. Also included is a description of the methodology of historical research, historiography, including study design, sources, an ethical discussion, data collection techniques, data analysis, and the proposed timeline for my thesis work. My goal, through my biographical historical research inquiry focusing on Mary Richmond and the transformation of nursing education post Second World War was to make a contribution towards the structure and development of nursing education today and in the future.

Chapter Three: The Educational Years 1937-1956

Richmond graduated from High School in 1937 during the Great Depression when unemployment rates for young Canadians were high. Richmond stated in her biographical information profile (Richmond, 1993) that due to her family's lower income status her options after high school were limited. As a result, she spent two and a half years volunteering with the Canadian Youth Congress (CYC). Established in Toronto in 1935 the CYC was an umbrella group for most of Canada's youth organizations and was started due to the economic hardship that challenged youth who came of age during the Great Depression. The CYC stood for peace and viewed war as a threat to economic and social stability. One of the main roles of the congress was to lobby governments to initiate change and in 1936 the Congress produced the Declaration of the Rights of Youth which called for youth employment training, improved health care, recreational and educational facilities and last but not least world peace (World Youth Congress Pamphlet, August 1938). The goals and vision of the Canadian Youth Congress such as peace, diversity, and civil liberties aligned with Richmond's philosophy as she noted in her biographical profile (Richmond, 1993) that she was a pacifist. The nursing ideals of caring for others was also one that Richmond believed in and it was this moral philosophy as well as economic necessity that she attributed to her choice to enter the nursing profession.

Vancouver General Hospital School of Nursing

Richmond's parents, while unable to afford to send her to university were in full support of her pursuing higher education so when she had earned enough money to attend and was finally old enough she applied to the VGH School of Nursing. Richmond described several reasons for her decision to enter the nursing profession. Career opportunities for women were limited at the time and there were many unemployed teachers but Richmond knew no

unemployed nurses. The Great Depression not only had a profound effect on BC's social, political, and economic status but on nursing and nursing education as well. When unemployment rates started to rise salaries decreased and there was no shortage of nurses to fill positions. Kelly (1973) points out, unemployment among nurses was so grim that in 1930 the Graduate Nurses Association requested that the size of the VGH training school be reduced in order to decrease the numbers of new nurses needing work and requested hiring more graduate nurses; they were already trained and would be less financially taxing to the hospital because of the decreased numbers that would need to be housed. Soon graduate nurses outnumbered students as employees of VGH. This shift constituted a turning point in nurse employment as it never reverted back to hospitals staffing their wards mainly with students (Kelly, 1973).

As a young adult, Richmond had two personal experiences that influenced her decision to enter the nursing profession. The biographical notes of her profile related how she observed a nurse visiting a neighbor as well as her grandmother; this was an inspiration to her. "The VON nurse visited a neighbor who was on a Bradford Frame with poliomyelitis and the nurse was a much respected person in the community for the care she took of Dolly. Also the VON visited our home to look after my grandmother. I thought they were pretty nice people and very useful" (Richmond, 1993). A Bradford Frame was essential to maintaining immobility and consisted of a rectangular pipe with canvas laced to it. No pillows or cushions were allowed and patients were carried around while strapped to the frame. To ensure immobility, splints on the affected limbs were attached to the frame and maintained until recovery occurred to a degree sufficient to permit useful function of the muscles and limbs, (<http://www.healthheritageresearch.com/MCPlague.html>). The care associated with this type of patient shows the complexity and nature of the knowledge nurses required. These combined

experiences brought nursing to the forefront for Richmond and influenced greatly her decision to enter nursing school at VGH.

The Vancouver General Hospital where Richmond started her nursing career was a long-standing hospital in the city. The hospital had been established as the Vancouver City hospital in the late 19th century. The Vancouver City Hospital Training School for Nurses commenced in October of 1899 with a three year curriculum program, thirteen years after the city of Vancouver and its hospital were established (Kelly, 1973). During this time the nursing profession demanded great sacrifices and was seen in the eyes of the public not just as a job but as a vocation and as such requiring a dedication to continue work in spite of long hours, poor wages, and unpleasant working conditions. The attitude and perception that hardship and suffering were normal and expected of a nurse and that in her selflessness and poverty she represented the ideals of womanhood persisted for many years. During the first several years of the training school the admission requirements were as follows: “the applicant must be over twenty and under thirty-five years of age. Exceptions to the age limit may be made when the candidate is otherwise particularly well prepared to undertake training. Educational requirement is three years of high school courses or its equivalent. Women of superior education and refinement will be given the preference” (Cavers, 1949, p.32). These requirements were somewhat limiting to young women such as Richmond who after graduating from high school needed to wait until she reached the age of twenty before she could enter the School of Nursing at VGH.

Many of the first hospital schools of nursing in Canada attempted to model themselves after the educational model known as the “Nightingale Model” of nursing education. For her efforts on behalf of the British troops in the Crimean War Florence Nightingale was propelled to heroic status in the western world. Nightingale’s supporters wanted her work to be recognized

so they began soliciting donations for a fund that Nightingale could use to promote the education of nurses; her stipulation however was that only she and the trustees would be able to control the use of the monies. McPherson (2005) notes that in the 1860s Nightingale and the trustees finally put the funds to use and established a Nursing School in conjunction with London's St. Thomas's Hospital. "The students were paid a small sum, learned as they worked on the wards, and upon completion of their training they were contractually bound to take a position at the hospital for a set period of time" (McPherson, 2005, p. 76). The most critical difference between the Nightingale system and the Canadian Hospital Schools of Nursing was that although the schools were to run independently from the hospitals they were unable to as the nursing schools did not have independent funding, akin to the Nightingale Fund, through which the nursing program could wield some leverage in negotiations with the institution. This concept of autonomy was lost, the schools became dependent on the financial stability of their associated hospitals and policies were dictated by hospital boards (Ross-Kerr, 1999). With the loss of financial independence the idea of a nursing school that was established primarily for educational purposes and training of nurses fell by the wayside and the education of nurses became secondary to the needs of the hospital. The hospital training schools soon became service oriented, the students became a source of cheap labour that was exploited for the financial gain of the hospital and the educational component of the schools took a back seat to hospital service demands. The first class of the VGH School graduated in 1902, setting an important trend for the way nursing education would be organized for decades to come.

VGH and UBC linkages

From 1919 onwards the VGH Hospital School of Nursing became linked with an academic component. In 1919 VGH and UBC created the first university nursing school in the

Commonwealth and offered its graduates the highest degree obtainable in the nursing field (Kelly, 1973, p. 47). Nursing became one of 21 departments under the only three faculties (Arts, Agriculture, and Applied Science) at UBC in 1919-1920. The plan for the program consisted of two years of university study, and then two years in a program at an approved hospital affiliated with UBC, and a final year of study at UBC. It was referred to as a non-integrated program and was typical of most Canadian university nursing programs until the integrated program was developed in the 1940's at the University of Toronto (Zilm & Warbineck, 1994, p. 30). The first year of the UBC nursing program had four students all approved and interviewed by Ethel Johns the new director of the Department of Nursing at UBC. The VGH Hospital School of Nursing continued on with the three year program resulting in a diploma in nursing. While this collaboration had its difficulties it did expand the opportunities and choices for women who wished to enter the nursing field.

Malcolm MacEachern, physician and the administrative director at VGH was the impetus for the start of this change in nursing education. He was very much in favour of academic education for nurses which he believed would result in improvements and standardization of hospitals overall. "He wanted to see a University of British Columbia Department of Nursing as the central institution for education of all nurses in the province, with various approved hospitals used for practical portions of the program" (Zilm & Warbineck, 1994, p. 21). Although this model did not evolve in its envisioned form, an academic nursing program did start, with VGH providing the practical portion of the new program. The options for nurses increased twofold as they could now choose the degree option or go directly into the hospital taking the three years of training and receiving a hospital diploma. In its initial years only a select few nurses went through the degree program, most nurses likely deterred by the length of the program, the

expense required, admission requirements, or perhaps the diploma program suited their needs at the time. “ But the university program conferred prestige on the Vancouver General Hospital and its School of Nursing and the opportunities for advanced education in public health nursing and in administration benefited both the nurses and the community around them” (Kelly, 1973, p. 49).

Anne S. Cavers was a graduate of the VGH School of Nursing in 1927, upon her graduation she became an instructor at the school and spent 20 years teaching at VGH until her retirement in 1947. Richmond mentions Cavers in her oral interview (1987) as an excellent teacher and one of the best role models and mentors Richmond could have had. In her retirement Cavers wrote the history of the VGH School of Nursing and it was produced for the schools fiftieth anniversary in 1949. In her book, Cavers, (1949) also refers to the affiliation with UBC and quotes Ethel Johns, then director of the VGH school of Nursing, from the annual report she made in 1920, “our connection with the University of British Columbia has unquestionably added to the prestige of the Training School and I am glad to report that eleven students are entered for the combined course in nursing leading to the degree” (p. 34). Another proponent of the affiliation, Maude McLeod (1919), former nursing superintendent at VGH described in *The Canadian Nurse* the benefits of the new degree program:

First, the connection of our training school with the University will bring it to a much higher plane and attract the best type of young women. Second, the teaching will be more thorough, systematic and efficient. Third, the great advantage to the patient in not being subjected to the untrained nurse, and fourth the connection of the training school with higher education and modern advancements will be more stimulus for nurses and attract the best class of young women to take the course. (p.2101)

The combined course, as the university-hospital program came to be called started with two years of classes at the university in topics such as English, chemistry, physics, economics, biology and bacteriology. The students then entered the nurses' training school at VGH and spent two years gaining practical experience and taking classes with the diploma students, including surgical nursing, diet in disease, obstetrical nursing, history of nursing, and ethics as well as many other nursing courses. The final year was spent back at the university "at which point the student elected to specialize in either public health or teaching and administration" (Kelly, 1973, p.52). The program continued as a joint venture for many years including those that Richmond spent at the VGH School of nursing where she referred to the program in her oral history interview as the "sandwich program". Richmond was not one of the combined students, she was a member of the diploma program but remembers fondly the opportunity given to her during her school years to participate in the psychiatric portion of nurses training in which seats were usually reserved for the UBC students. Community health and the provincial mental hospital portions of the training program could only accept a limited number of students, Richmond was fortunate that during her training years there were more spaces than the UBC students needed and as a result she had the opportunity to be part of the training component at the mental hospital Essondale, which was the site of the Provincial Mental Health Services Hospital, located in Port Coquitlam, BC. Richmond spent two months at Essondale and described in her oral interview how there were students from several different training hospitals around the province that participated. This gave Richmond and the other students from VGH and UBC the opportunity to meet, mingle, and get to know students from other schools. Richmond (1987) discussed many meaningful experiences that she had during her training years. These included: doing blood transfusions which was certainly not as common as it is now; caring

for a patient in an Iron Lung (he was in it for 10 years); and tuberculosis (TB) nursing.

According to Richmond (1987) BC was the first province to require student nurses have an experience with TB clients and was also the first province to eliminate it from the curriculum due to the number of declining TB cases in the late 1950s.

As a student during the war years Richmond remembered the blackouts and wartime practice drills and in particular a very difficult experience trying to comfort the family of a patient that was dying, in the eerie blue light that was a result of having to have all the lights turned off. With little experience comforting mourners Richmond remembers this as a very challenging experience. The wartime years had a significant influence on changes to the nursing profession and nursing education. Overnight the province of BC climbed out of the Depression and the economy strengthened during the 1940s due to wartime demand for goods and services. For the first time in over 10 years the need for workers outstripped those searching for work and nursing was no exception (Zilm & Warbineck, 1994).

The Second World War while not the beginning of women in the workforce was the context for an enormous expansion of women's work. Statistics show that there were more women employed during the war years than any other time prior to it. Due to necessity women penetrated the world of work which had previously been the domain of men. However, any gains earned for women in moving outside of the home to work during the war were lost immediately when the soldiers returned home. Ross-Kerr (1998) stated, since civilian women were generally told to leave the positions they had filled so well during the war, one might think that this happened for nurses as well. However it did not, for the post war period was a time of great expansion in health care, and with the advent of Medicare, the demand for nurses was greater than it had been during the war years. Being a member of a sex-segregated profession

was advantageous at the time because women were viewed as the only ones who could perform nursing roles and thus society did not demand that they now return home to their domestic duties. Married women were also recruited into the nursing workforce because of expanding demand.

As the VGH Nursing School existed 50 years in 1949 one of the most significant issues that plagued nursing and nursing education was the shortage of nurses. This was not a local issue but felt throughout the western world after the Second World War and had significant impact on changes to the nursing profession. The high rates of unemployment during the depression years had discouraged women from entering the nursing field and had also meant that schools had to cut the number of seats available. Finally, during and after the war the demand for nurses increased faster than the system could produce them (Kelly, 1973, p. 113). There were several factors that influenced the shortage including smaller schools of nursing that had to close because their facilities could not meet the demands of higher standardization of nursing education; increased numbers of students meant the requirement for increased number of spaces to house and teach them; competing demands on hospital funds meant the needs of nurses slid to the bottom of the list; societal demands for more nurses kept increasing as the population grew; nurses went overseas to nurse in the war; and there was also competing demands for nurses from different government facilities. The shortage of nurses greatly influenced policy changes at the school, including the hiring of instructors who had special preparation at schools such as UBC and McGill and the initiation of a partial block system of instruction for probationers and junior students.

Richmond (1987) explained how the block system was an attempt to balance the educational needs of the students with the service needs of the hospital. “Various efforts were

made to develop the block system, where the students had a period of time in the classroom and then a subsequent period of clinical practice on the wards. The difficulty lay in trying to relate the clinical practice as much as possible to the educational content that was part of the blocks of time. It was very difficult to do because when a significant number of students were taken off the wards for classroom time it left the wards depleted so several attempts were made to find the balance". Kelly (1973) noted that the basic idea of the block system was that certain periods of time, such as a week, would be given over to classroom instruction alone, so that the fields of study could be more rationally taught and so the student would "not find herself continually interrupting her ward work for classes and vice-versa, and would not have classes on her much needed days off" (p. 118). The significance of this change in nursing education was that it resulted in the acknowledgement that classroom sessions were an important piece of the nurse's education. Richmond (1987) also stated that the classroom material shifted to a more clinical content and the instructors also transitioned becoming more clinically based as they moved out of the classroom and onto the wards. Richmond described her first experience as an instructor in 1946 at VGH where she felt very much resented by the head nurse who regarded the wards as her territory.

Throughout the development of hospital-based nursing education the question how to best administer nursing education in combination with the academic portion of it at UBC remained an ongoing question. When Ethel Johns was appointed the first Director of the Department of Nursing at UBC she was also the Director of Nursing at VGH, overseeing nursing education at the hospital. This combined role carried on for several years but eventually it was realized that Johns could not administer both educational programs and protect both groups. In

1921 the position was divided between two people and resulted in a Director of Nursing for the Hospital, and a Director of Nursing Education in the hospital program.

Upon her graduation in 1943 Richmond remained at VGH as a staff nurse from 1943-45 and then as an instructor in the diploma program from 1946-50. Upon returning to BC after completing her Bachelor's degree at McGill University in 1951 Richmond took on several leadership positions over the next decades. These included positions of both the Director of Nursing and the Director of Educational Resources at VGH and RJH. During this time she wrote several papers and gave several speeches in regards to role definition and the complexity of these nursing leadership positions that will be discussed later in the paper.

McGill University

As previously mentioned Anne Cavers who was one of Richmond's instructors at VGH was a strong role model for Richmond, a well-loved teacher and as Richmond stated "she made me want to teach" (Richmond, 1993). This mentorship inspired Richmond to become a teacher, as a result in 1946 and 1951 Richmond attended McGill University and obtained a Diploma in Teaching and Supervision, a Diploma in Administration, and her Bachelor of Nursing Degree.

In October of 1920 after many hurdles the school for nurses who had graduated from diploma programs was opened at McGill University. At the university, graduated nurses could specialize in two fields, and with eight months of study obtain a university diploma in either public health or teaching and supervision (Tunis, 1966). This was the beginning of an important new opportunity to obtain specialized academic education in nursing in Canada but it was also the beginning of a prolonged struggle to establish the McGill School as an integral part of the university and to maintain and increase standards of nursing education at an academic level. Like many universities and schools of nursing McGill suffered during the depression and was

even close to closing at one point. During the war years the school struggled to meet the nursing shortage demands but by 1943 the School for Graduate Nurses was still the only university school in Canada offering post-basic courses in nursing education for graduate nurses. Several of the other university programs across Canada offered specialty courses in public health and administration but not a specialty course in the teaching of nurses.

Access to education specific for nurse educators was most likely the main reason Richmond left BC. After graduating from VGH in 1943 and spending a few years working as a general duty nurse at the VGH Richmond was looking to further her education and to become a nursing instructor. As McGill was the only university to offer this type of specialty course Richmond attended McGill and received a diploma in teaching and supervision and then came back to VGH to be an instructor at her Alma Mater for several years. Richmond knew that if she wanted to move forward in her career she would need to pursue further education and she received her diploma in administration in 1951 as well as her Bachelor of Nursing degree from McGill University. Richmond (1987) stated “I found it a great change from BC, learned a lot about academic life and definitely appreciated the opportunity to go to McGill and further my education”. Richmond (1993) mentioned several people she got to know at McGill who were instrumental in shaping her career; Marion Lindeburgh being chief among them. Lindeburgh came to McGill in 1929 following six years as a Director of the Health Education Department of the Provincial Normal School at Regina and was associated with the McGill School of Nursing for more than twenty years (Tunis, 1966). Lindeburgh was the acting director in 1934-39 after the death of Bertha Harmer, McGill School of Nursing’s first director, and then director from 1939-51. Harmer had been one of Lindbergh’s former instructors and director. In *Caps and Gowns*, Tunis (1966), described Lindeburgh as a beloved teacher, a staunch friend and an

indefatigable colleague. She was instrumental in raising funds for the school during a time of great fiscal restraint; was largely responsible for the *Proposed Curriculum for Nursing Schools in Canada* (1936); and while serving on the executive of the Canadian Nurses Association (CNA) she was a vital force in raising standards of nursing education and service in Canada. Richmond singled out Lindeburgh as one of her mentors during her time at McGill and stated that she opened her eyes to a different way of viewing the world, was a great role model, and helped Richmond to envision her future nursing leadership roles.

From 1920-29 the school at McGill offered three programs that lead to the granting of a certificate diploma in either public health nursing, teaching and supervision in schools of nursing, and administration in schools of nursing after one year of study. Between the years of 1929-1936 the school for Graduate Nurses expanded their two year diploma course offerings to include: courses in teaching in schools of nursing, supervision in hospitals and schools of nursing, administration in hospitals and schools of nursing, visiting nursing and health teaching, and supervision and organization in public health nursing that lead to a diploma after two years. In 1936 due to the effects of the Depression and the beginning of the nursing shortage in Canada, McGill reduced the study time and offered teaching and supervision in schools of nursing, administration in hospitals and schools of nursing, public health nursing and administration and supervision in public health nursing after only one year of studies.

While Richmond studied at McGill, the program continued to expand with the incorporation of a program leading to a Bachelor of Nursing Degree. In 1943 in an attempt to continue to move the school forward recommendations from the Senate Committee on nursing education were put forward which included: in 1944 a two year post basic course of study leading to a Bachelor of Nursing degree be established; that McGill assume full responsibility for

the school; that the school retain its affiliation with the Faculty of Medicine; that the one-year certificate courses be continued while the needs existed; and that the director of the school be invited to become a member of the Faculty of Medicine (Tunis, 1966, p. 75).

In 1944 a two year course leading to a BN degree commenced and the one year certificate courses continued. In addition to the original certificate courses several other certificate courses were introduced including supervision in psychiatric nursing, supervision in obstetric nursing and supervision in paediatric nursing. In 1957 McGill started offering a basic baccalaureate program which was a five year course for high school graduates that resulted in a BScN. The final change in the McGill program occurred in 1961 when the postgraduate degree program commenced leading to a M.Sc. (applied) with an opportunity to major in nursing education or nursing service administration. McGill took a principle role in the transformation to baccalaureate nursing education in Canada and provided Richmond with a unique opportunity to witness the transformation and most likely influenced her decision to obtain her Master's degree. It also gave her a reference point for her work in developing an academic nursing program at UVIC. After obtaining her Bachelor of Nursing degree Richmond left McGill and took up a newly created position as the Director of Nursing Education at the Royal Jubilee Hospital in Victoria, BC.

Still McGill kept its pull for Richmond and she returned in 1960 when the Master's program was starting at McGill. Richmond (1987) noted that she wanted to become a part of the development of a Master's program so she left her post as Director of Nursing at the RJH and spent 4 years at McGill as an assistant professor. A student of Richmond's at McGill, J. Mantle remembers the medical-surgical nursing course that Richmond taught and how important nursing linkages were to Richmond. "After Mary's return to Vancouver she would periodically call

together her former McGill students to have supper at her home and we would share our current lives and experiences with each other, I remember it fondly” (J. Mantle, personal communication, November 3, 2014). Richmond noted in her oral history that although the work she did at McGill during this time was invaluable the experience had given her new insights about the requirements of an academic teaching career. Likely as she learned about the expectations for university teaching she realized that a doctoral degree was an important step for teaching at a Masters level. Richmond did not take her career in that direction though, although her academic experience would prove valuable when academic nursing expanded in the 1970’s. Richmond was not alone in her experience of moving between clinical leadership roles and academia. As described by Boschma (2005) Margaret Scott Wright, a nursing leader from the UK who was appointed Dean of the Faculty of Nursing at the University of Calgary in 1979 also moved between roles in clinical leadership and roles in academia and research. Scott Wright was a graduate of London’s St. George Hospital School of Nursing. Her clinical experiences as staff nurse and ward matron “gave her insight into just how much nursing education would have to change to assure an advanced skill and knowledge base, sufficient clinical training, and confidence in decision making to meet new nursing demands” (Boschma, 2005, p. 87). Scott Wright was instrumental in the transformation of nursing education during the 1960s and 1970s both in Britain and in Canada. Richmond’s career path is similar to Wright Scott and so in 1964 Richmond was happy to return to BC to become the Director of Nursing at Vancouver General Hospital, a position she held for 11 years.

Columbia University

Between Richmond’s time as Director of Nursing Education at RJH and the Director of Nursing at RJH Richmond went to Columbia University in New York to obtain her Master’s

degree. Always a proponent of higher education for nurses and feeling she needed to continue her own education in order to fulfill her roles to her fullest capacity she travelled to the US to complete her goal. The program at Columbia University was well known internationally and many nurse leaders in the mid-twentieth century obtained their degree at Teacher's College at Columbia University. The Columbia School of Nursing was founded in 1892 and since its inception the mission of the School had been the preparation of clinically excellent nurse practitioners, clinical nurse specialists, and scholars. The relationships between Canadian and United States' Schools of Nursing had been growing and transforming over time. Until 1919, Canadian nurses wishing to further their education had to go to the US to do so. Many of them never returned, in fact Canadian women played a significant part in the development of the nursing profession in America. Tunis (1966) described Isabel Hampton Robb, a Canadian superintendent of nurses at the Johns Hopkins Hospital School of Nursing (1889-94) and a pioneer nurse educator who was instrumental in the creation of the Hospital Economics course at Teacher's college, Columbia University in 1899. The School of Nursing was the first in the US to award a master's degree in a clinical nursing specialty in 1956, (<http://www.cumc.columbia.edu/nursing/about/history.htm>). It is because of the closely knit professional nursing relationship between the US and Canada as well as the lack of Master's programs in Canada during the first half of the 20th Century that so many Canadian nurses travelled to Columbia University to obtain their Master's degrees as did Richmond. She described (1987) the long established nursing program at Columbia University and while she did take an elective in teaching as part of the Master's program, she wanted to be a director of nursing service as it seemed to her the best way to marry the two positions of director of nursing service and director of education.

Summary

There were several influencing factors for Richmond entering the nursing profession but in the end the most crucial factor was that nursing aligned with her personal belief and ethics. Her experiences during nurses training as well as her desire to continually expand her knowledge base kept her moving forward in her career and educational pursuits. In the following chapter I will examine the professional roles that she held and how the social, cultural, economic and political issues during her years as a leader in the nursing profession influenced her work and how she worked towards making changes in nursing service and education in respect to the roles she held as Director of Nursing, Director of Educational Resources, and University Professor.

Chapter Four: Mary Richmond's Professional Roles

Director of Nursing and Schools of Nursing in the 1950s to 1960s: Issues and Themes

After completing a Bachelor's degree at McGill University in 1951 Mary Richmond returned to BC and took up the position of the Director of the School of Nursing at Royal Jubilee Hospital in Victoria from 1951-1955. It was one of several significant leadership positions she held over the years. Richmond brought in and modernized the nursing school curriculum at RJH. It was a time when Richmond became a significant member of the nursing leadership in Canada as she had advanced education in the form of her Master's degree from Columbia University which at the time (1950s) was an important milestone in becoming a nursing leader, (J. Mantel, personal communication, November 3, 2014)

Richmond (1987) touched on several issues that she had to deal with in her role as director and which were of importance in nursing education. The main issues were trying to balance the educational needs of students with the service demands of the hospital, providing nursing students with an education program that would meet the changing needs of patients, increased acuity, advancing technology, and ensuring there were leaders to provide the education required. Tensions between educational needs and service demands were not a new issue in the 1950s. Already in the 1930s, scholar and politician George Weir had conducted an extensive survey of nursing education in Canada and had made several recommendations for improving nursing education as well as identifying several persistent problems with hospitals operating schools of nursing. George Weir was a professor and the first head of the department of education at UBC; he also taught in the final year of the UBC Department of Nursing and in 1933 became the provincial secretary and minister of education in the new Liberal government (Zilm & Warbineck, 1994). In his *Survey of Nursing Education in Canada*, Weir (1932), recommended the establishment of a comprehensive, organized system of supervision and

control of nursing personnel and service in Canada. He also recommended that nursing should be regarded as a profession, instructors of nurses should have a grounding in the fundamental principles of the science of education, much greater use of the problem solving method of teaching should be introduced, and finally it was recommended that as soon as possible the training school for nurses be established primarily as an educational institution closely affiliated with the hospital but enjoying financial independence. Ross-Kerr (1998) points out that the establishment of schools of nursing at the turn of the 20th century was a definite asset to hospitals because the students recruited to the schools provided the means by which the nursing service of the hospital could be rendered at minimal expense. Clinical assignments were not based on the students education needs but on the service needs of the patient care units and that hospital schools of nursing used their students as a workforce; that hours on duty were too long; that nursing instruction in the classroom was limited and insufficient; and that teaching personnel were ill-prepared and too few in number (Ross-Kerr, 1998, p 132). The results of several surveys on nursing education that were completed during this time were the impetus for change that had been growing since the 1930s. As a result of the surveys, research, and growing pressures during the 1960s hospital schools of nursing began to close, the community college movement grew in strength and nursing education began to move away from hospital based programs and into the general educational system. Colleges and universities became places where nursing students were offered increased time and training to devote to their studies resulting in a better prepared workforce which was being demanded by the public.

Balancing in-class learning and practice

One of the other changes that occurred in the hospital based nursing education was the institution of the block system of nurses training. I touched on this earlier as Richmond

described the system in her oral interview (1987). The block system was instituted in order to find balance between classroom and practical application of the knowledge. In the block system, there was a period of time in the classroom and a subsequent period of time on the wards. Educators were striving to assist the students to relate the clinical practice to the blocks of time they had in the classroom. This was difficult to achieve because as students were taken off the ward for classroom instruction it left the ward deprived of a significant portion of staff. In addition, students were divided into several groups and taken off the wards one group at a time to complete their classroom instruction within a three week time period; however, this meant that the content of the lectures must be repeated several times for each individual group. Nonetheless the block system had both advantages and disadvantages. Kelly (1973) describes that in 1949 the new system was pronounced a success which was evidenced by the student's examination results which resulted from the intensive schedule and increased time for study. It was also noted that the block system was an important innovation in nursing education as it showed the importance of classwork in the student's training; theory and classroom work were beginning to come to the forefront of nurse's education rather than it being a secondary focus behind the financial aspects that hospitals gained from students providing the nursing service. The block system still had "its flaws, however, for the classes were not correlated with the work on the wards. Under the twelve week rotation system the students had to receive some of the ward experiences as much as six months after the relevant classes" (Kelly, 1973, p. 120). A full block system at VGH did not come into effect for another ten years (1960) largely due to the fact that meeting hospital demands for nursing service still outweighed the importance of providing an essential and applicable learning environment for student nurses.

Educational content and technological changes

Richmond (1987) mentioned how the content of what students learned changed and became more clinically focused. Hands on experiences were the preferred method of instruction as it had the potential of introducing students to most activities that took place in a hospital. There were drawbacks to this method as well. Ross-Kerr (1998), describes in *Prepared to Care* that there was a lack of variety of clinical experiences in schools operated by small hospitals and in larger institutions it was not uncommon for students to remain for long periods of time on a few units in order to satisfy the staffing needs of the hospital. Health care technological advancements were occurring on a continual basis as research was performed, and new techniques were discovered. As medicine progressed the nursing field also needed to adapt to the changes and discover new ways of imparting the information to students and current staff and to make continual changes in becoming and maintaining the profession. Ross-Kerr (1998) states that from the 1950s, increasing technology in the health care and medical fields meant that there was greater diversification in nursing roles and nurses were required to become highly skilled technically in order to perform the complex procedures that were required by the hospital patients. As the use and availability of antibiotics had increased since the 1940s and vaccines were discovered the types of patients in hospitals began to change dramatically. Polio for example was common in many Canadian hospitals starting in the 1920s and then was eventually declared eradicated by the late 1960s as a result of the development of the Polio vaccine. This is just one example of a technological change that had a significant impact on the nursing profession, on the work that nurses do, and on the nursing education required to provide safe patient care. As the number of patients with infectious diseases was on the decline the technological advancements in surgical procedures meant that hospital in-patient facilities

devoted more of the care time to surgical patients and this had a dramatic effect on nursing practice. Surgical units required large numbers of nursing personnel to operate them, and “because surgical methods required rigid adherence to aseptic technique before, during and following surgery, nurses’ knowledge and skills were needed to provide wound care, applying the principles of asepsis to prevent infections of operative sites” (Ross-Kerr, 1998, p. 58). Blood transfusions were another medical technology that changed over the years and altered nurses’ work as well. In the 1930s blood transfusions were complicated treatments that involved several people, usually two nurses and a doctor, but as technology advanced the procedure, as with others, it became less complicated, required less people, and was eventually delegated or became a normal part of nurse’s work. Richmond (1987) remembered her first experience in the operating room when blood was being given. At the time the donor went to the operating room to donate blood and was then given an ounce of brandy afterwards as a way of decreasing their blood pressure. Richmond goes on to state that at the time, blood was given through an open burette with gauze over the burette and blood poured through the gauze to filter out any clots and she remembered that only small amounts of blood were transfused, about 250cc at a time. Nurses had to sit with the patient and take their pulse every 10 minutes or so. They were watching for complications to the blood such as an increased pulse rate or skin rash. Finally, Richmond described how donors had to be solicited, this involved the ward staff or head nurse contacting the family to round up donors and then cross matches were done. Also, taking blood pressures gradually became a domain of nursing expertise in the 1950s. Up until then the procedure of taking a patient’s blood pressure was the domain of physicians. During the early 1950s hospital policies “clearly stated that only specially trained nurses could take blood pressures and then only under specific circumstances: nurses may take blood pressure readings

on skull or accident cases at regular intervals after midnight, but by 1954, blood pressure measurement was also a standard skill expected of all nurses” (Bates, Dodd & Rousseau, 2005, p. 100). Richmond’s testimony about the technological changes she was a part of provides a glimpse into the ongoing changes in nursing education and work during the 1950s. Besides a changing work context and demand for more qualification, nursing leaders also experienced pressure to meet the rapidly expanding demand for nurses.

Balancing resources: shortage of nurses and nursing leaders

A significant issue in Canadian nursing history is touched on by Richmond in her oral interview (1987), the nursing shortage post Second World War, was not only for staff nurses but also for nursing instructors and nursing leaders. The shortage of nurses began in the 1940s and reached a significant peak across the globe during the years of the Second World War. The basic problem was that the demand was increasing faster than the existing system could produce nurses. Prior to the Second World War nursing and teaching were the only two respectable professions for women. After the war, opportunities for women in the workforce expanded and leaders in nursing needed to look at ways of making the profession more attractive to women. Kelly (1973) described the conference in 1941 that the Canadian Nurses Association (CNA) held to address the issue. The recommendations that came out of the conference included grants to assist in quickly preparing women of limited experience for positions of responsibility; funds for refresher and graduate courses for married and retired nurses; contacting high schools and neighbourhood groups to interest girls in nursing; and the CNA emphasized the responsibility of the hospitals to make working conditions more tempting for both students and graduates. This became an impetus for nurses unionizing and bringing pressure to produce improvements in hours, wages and working conditions (p. 77).

The lack of registered nursing leaders meant that there was a lack of role models for students to witness and ask questions of and observe in practice. Zilm and Warbineck (1994) note in their *History of Nursing education at UBC* that Evelyn Mallory (Director of the UBC school of nursing) pointed out “there is a tragic dearth of persons qualified for senior level positions in nursing service and nursing education and of nurses qualified to act as clinical nursing experts to help effect improvement in patient care. These needs are urgent and can only be met through graduate programs” (p. 142). The shortage of nursing leaders and teachers in post war Canada set the foundation for changes in nursing education. UBC as with many other institutions across Canada was continually changing curriculum, certificate courses that were once offered in teaching and supervision were eliminated as leading experts in nursing education felt that nursing instructors needed at least a basic nursing degree and post graduate study. Nursing leaders recognized that nursing, if it were to keep pace with changes in health care needed well prepared teachers.

Changes in demographics

The growing population in BC certainly affected nursing service and education. With increased population demands there were changes made to the number of students entering nursing programs, the facilities available, and the training provided. In fact it was at this time that the struggles between UBC and VGH over nursing education began to grow. For over 40 years VGH had essentially supported two nursing education programs, a regular hospital-based School of Nursing and the so-called “sandwich program” that accommodated UBC nursing students. The latter existed of the combined university and hospital-based nursing education program, in which UBC nursing students took a year of university education, then the hospital-based education at VGH for three years after which they completed their university education

with another year of university courses. The sandwich program for UBC students which Richmond discussed in her oral interview (1987) had been in operation for nearly forty years, but as the half century mark passed both the university and hospital were growing increasingly dissatisfied with it. Class size was growing at UBC causing increased strain on the combined program and “UBC students at VGH were aware of some jealousy over the fact that they were receiving a fuller educational program, with strong support from their own UBC faculty and preferential rotations that gave better integration of theory and practice” (Zilm & Warbineck, 1994, p. 123). The UBC and VGH students spent different amounts of training time in their programs, it was difficult to have the degree students moving in and out of classes and clinical time, and resources for clinical experiences were stretched to the limit. As a result the UBC faculty looked for a different model and even though there were efforts made to create changes to accommodate all interested parties UBC moved forward with a plan to change the arrangements for clinical placements. In the early 1960s UBC moved away from a solely VGH based program and made arrangements for their students to have clinical experiences at other hospitals in Vancouver as well, such as St Paul’s Hospital. “The program was now officially described as an integrated program which included preparation for staff level positions in public health nursing as well as work in hospital. It also included preparation for teaching and a consideration of the fundamentals of ward management and supervision” (Zilm & Warbineck, 1994, p. 140). In 1965 UBC and VGH re-established their relationship and negotiations began in order for UBC students to have clinical placements at VGH. As a result second and third year students returned to VGH for specific clinical experiences such as at the health center for children. As this transformation took place, Richmond became the new Director of Nursing at VGH.

Changing Context of Nursing Practice

Following her directorship of the School of Nursing at the Royal Jubilee Hospital in Victoria, Richmond had become an administrative leader at the hospital. In 1956, she moved from her position as Director of the School of Nursing to one as Director of Nursing at the Royal Jubilee Hospital in Victoria, a position she held from 1956 to 1960. Thereafter she returned to VGH as the Director of Nursing. She stayed in this position from 1964 to 1973. Richmond discussed several issues and struggles for nursing administration that were occurring during these years. Richmond (1987) stated that during all of the years she spent as a Director and even into the 80's and 90's the main struggle was to find enough nursing staff and enough budgets for the nursing staff to provide the care that was required. In conjunction with this was the issue of workload and finding ways to control it. The second issue that Richmond mentioned was the instigation of hospital insurance which eased the budget problems of hospitals but not necessarily the nursing departments. In order to alleviate budget and staffing problems several ideas were looked at including the changes of who was accepted into the nursing workforce such as the changes in private duty nursing and the increasing acceptance of married women in the workforce. Richmond also discussed how certain duties that nurses typically did but were not necessarily related to nursing began to be assigned to non-nursing personnel. Part of this change was the introduction of the unit clerk to alleviate the head nurses from doing secretarial work. Nursing service and nursing education were continually transforming in the years Richmond spent as director of RJH and VGH. Moving forward I will discuss how the issues of hospital insurance, private duty nursing and married nurses in the workforce were key elements in the changes occurring in nursing service as well as nursing education. Thereafter I will also discuss

how these changes affected the change in the role of the director of nursing, about which Richmond makes important comments in her oral history.

Hospital insurance

Post Second World War was a period of expansion for nursing across the country. “The passage of The Hospital Insurance and Diagnostic Services Act in 1957 was the cornerstone for Medicare in Canada, for it was the Act that provided for national hospitalization insurance” (Ross-Kerr, 1998, p.54). With the funding of hospitals coming from the public sector and governments providing an influx of financial support, hospitals, for the first time had stable budgets. The unintentional side effect of this was a greater emphasis on hospital-based care and decreased emphasis on public health and community care. Demand for health care services was increasing, and money suddenly poured into constructing new hospitals, and enlarging and modernizing existing ones. Richmond believed (1987) that the condition that really made possible the disentanglement of nursing service and nursing education was the development of hospital insurance. It gave the hospitals a significant financial way of paying staff other than just relying on student service. This change in focus greatly affected the education of nurses and was one of the impetuses for nursing education to move away from the hospital based model and into the colleges and universities. Furthermore, hospitals increasingly began to experience the payment for schools of nursing as a financial burden. This change in focus to clinical hospital nursing which had begun in the 1940s and continued with the shortage of nurses during the Second World War was part of the impetus for the CNA and the Canadian Red Cross to fund a first, experimental special school in Ontario that would prepare clinical nurses in a shorter period of time. Zilm and Warbineck (1994) describe “the Metropolitan School prepared diploma nurses in two years rather than three because the school was under educational control and the

students were not used to provide service in exchange for their education” (p. 122). It was this school that became the prototype for the move to two year nursing diploma programs in community colleges. In 1967, the BC Institute of Technology (BCIT) became the first of BC’s community colleges to open a two-year diploma nursing program. “This shorter, non-hospital program was the first in BC to follow the changing pattern of nursing education in Canada” (Zilm & Warbineck, 1994, p. 143). Then in 1968 the Medical Care Act provided national insurance for medical costs and completed the initial series of federal legislative acts establishing a national system of health insurance. All of these changes resulted in the need and demand for nursing services and opened up greater career opportunities for nurses. It also transformed existing models of nursing care provision such as private duty nursing.

Shift from private to public nursing care delivery

In the first few decades of the 20th Century when nurses finished training and graduated from nursing school the prime area for employment was as a private duty nurse, who took care of sick patients for pay in families’ private homes. Because students staffed hospitals in exchange for training, hospitals did not hire graduate nurses unless it was for leadership positions such as head nurses or directors. Bates, Dodd and Rousseau (2005) describe how prior to the Second World War, 43 percent of nurses worked in private duty while 26 percent were employed in institutions and 20 percent in public health. The interwar years brought a crisis to private duty nursing not just due to the depression but due in part to hospital training schools graduating large amounts of students and care of the ill turning away from the home and into the hospitals. As the nursing shortage began in the 1940s and 1950s there was a shift and private duty nurses who used to be employed directly by the patients were soon being hired by hospital administrators to provide care in the hospitals. Richmond (1987) mentioned that written in the Hospital Insurance

Act was the statement that necessary nursing care would be provided. As care became more complex it became apparent that students were unable to provide the type of care required and as such with changes in public demand and legislation the private duty nurse soon came to be a sought after provider of hospital care. Private duty nurses were well trained graduate nurses who could fulfill the care needs of the increasingly complex hospitalized patient. In fact, the RNABC used to maintain a private duty registrar but after the Hospital Insurance Act came into being the registrar started to be used by hospitals as they were required to provide exceptional nursing care which the public was demanding and which was believed to at the time, only be provided by graduate nurses (Kelly 1973). The role of the private duty nurse has changed over the years but it has never really been eliminated. As the role changed the private duty nurse moved away from the dependence on physician's recommendations for work to the current model of private home care agencies that are hired directly by clients to provide care, treatment and companionship in the home. This may be part of the current larger trend of health care moving towards a more community or home base model. Ross-Kerr (2003) noted that the number of nurses working in hospitals has continued to decrease after the large increase in the 1970s and early 1980s, while the numbers have continued to increase in related health care institutions, such as nursing homes, and in diagnostic and therapeutic services, such as visiting home nurses (p.233).

Married nurses

The constant desire to meet all of the health demands of Canadian society simply exhausted the supply of nurses and with the nursing shortage that began in the 1940s an underused group of skilled nurses was reintroduced back into the nursing workforce; married nurses. The social pressures prior to the Second World War prevented married women from

working outside of the home. Even decades after it became acceptable for women to work it remained unacceptable for married women to hold a job outside of the family home. It was the expectation that women would marry and once married would devote all of their time and attention to managing the home, caring for the children and attending to their husband. Wars have a significant impact on changing the ways of society and the Second World War was no exception. “Although married women were enticed into the workforce during the war years to fill the shortages caused by men who had left their civilian posts when they entered the armed forces, upon cessation of hostilities there was a well-orchestrated campaign to encourage women to leave the workforce and return to their homes“ (Ross-Kerr, 1998, p. 60). While some did leave the workforce, many fought for the opportunity to stay and continue to contribute to society in addition to maintaining their homemaking activities. Scaia (2013) also describes how nursing was thought of as a good preparation for motherhood and married life. Scaia shows through her oral interviews that many women who went into nursing felt it would be a good back up if something went wrong in the marriage or as a way to augment the household wages. "A career in nursing gave women the chance to become independent consumers and to be included in the new ‘social revolution’ of waged married women. It was the status and upward mobility conferred by attaining a university degree in nursing that made participation in the new consumer society more possible” (Scaia, 2013, p. 94). The nursing profession may have been less affected by the phenomenon of women returning to the home as nursing was considered women’s work and unsuitable for men. There was in fact an extensive effort in Canada during the 1950s to attract married nurses back to the active nursing workforce. Boschma (2005) describes how the Alberta Association of Registered Nurses created a refresher course in nursing, and local chapters arranged clinical practice to entice married nurses back to work. Married nurses were

graduate nurses and as technology advanced, hospital care became more affordable, and the public demanded expert quality health care it was the graduate nurse who could provide the level of care and experience required and as such married nurses were in the perfect position to re-enter the workforce. Richmond (1987) noted that until significant number of married nurses returned to the workforce there was no one else to care for the patients on the ward other than the students. In fact Richmond, in her role as the Director of Nursing at VGH initiated the innovation of married women returning to the nursing profession at VGH and in “1965 and 1966 a dozen married nurses were allowed by the VGH Board of Directors to return to the school. In 1967 the Director of Nursing was given full authority to grant or deny married students permission to remain in school after marriage” (Kelly, 1973, p. 88).

Re-assignment of responsibilities

As the shortage of nurses reached a critical point nursing directors and hospital administrators began to examine the scope of nursing practice and determine what parts of nurse’s work were better allotted to other disciplines. The shortage spawned a new category of worker, the nurse assistant or nursing aide. “Undoubtedly because of the economics involving lower salaries for this category of worker, hospitals hired them to ease the shortage during the war years. After the war this role was not phased out and training programs were established to prepare this type of worker in larger numbers” (Ross-Kerr, 1998, p. 224). There was some resistance from registered nurses and school staff around the training and employment of this new group as it was felt that some of the duties and responsibilities were being taken away from registered nurses. It was widely felt that only a trained nurse should perform nursing duties “such as giving enemas and preparing patients for operations but the increasingly complex duties of the nurse did not allow her time for tasks that could be taken over by others” (Kelly, 1973,

p.130). The shortage of nurses was acute and as a result health care leaders needed to examine new and innovative methods for delivering care to patients. After the introduction of this new role to alleviate the shortage it was never phased out and training programs were later established to prepare even more nurses' aides. Richmond (1987) recalled the institution of ward clerks as being another new category of worker that was introduced to relieve the nurse of non-nursing duties thus allowing her more time to concentrate on the complex care needs of the patients. Richmond noted that it was a struggle to get ward clerks established. One early research study that the CNA sponsored was called the Head Nurses Activity Study. It began in 1951 and was conducted by the research division of the Canadian Nurses Association in cooperation with the Ottawa Civic hospital. Botsford (1955) described how the study was initiated with the idea of developing a way to investigate nursing functions in a hospital. The purpose of the study was to answer the following questions; what does the head nurse do, how frequently does she carry out various activities, what proportion of her time is spent in activities of different types, and is she performing any duties from which she could be relieved? Botsford's (1955) results showed that head nurses were spending a majority of their time doing clerical work and also that the head nurse was constantly being overwhelmed with the detail of ward routines and as her work was divided into short term activities, she never had enough time to spend on any one thing. It was this study that gave thrust to hiring ward clerks to relieve some of the duties of the head nurses and to the movement towards expanding the higher level functions of the head nurse such as leadership, education and ward management.

Change in the director's role

The changes in the nursing workforce also had implications for new demands and issues in the Director of Nursing role. Richmond described many issues that directors of nursing had to

deal with during this time including balancing budgets and staff, controlling workload, defining nursing's scope of practice to ensure non-nursing duties were performed by the appropriate person, and being part of the change to ensure trained graduate nurses staffed hospitals and students received appropriate training in school. Richmond (1987) discussed the organizational structure of these large hospitals and how it changed over time with changing practice and needs. In the early days when hospitals had schools of nursing and depended greatly on students to provide the nursing service in hospitals it was appropriate for the director of nursing to be responsible not only for the care of the patients but also for the education of the students because the two functions needed to be integrated. However as the service load of students was eliminated it became more appropriate for the responsibility of nursing service and nursing education to be separated. During the 1960s and 1970s the structure of hospitals began to change and the Director of Nursing would have two assistants; one in charge of nursing service and the other in charge of nursing education.

Richmond (1987) also described how the role and expectation of the senior person in nursing altered over time. Initially when Richmond first became a Director of Nursing she had a mainly clinical, professional role in the hospital, seeing and caring for patients, having a fair grasp of what was going on with the patients, and was assumed by even the patients to have a wide variety of roles and responsibilities. Over time however it was recognized that nursing was one of the largest proportion of the hospital operating budget and should therefore have a larger voice in the planning of the hospitals and the decisions that needed to be made. As a result the expectation was that the role of the director of nursing not only be a clinical/professional one but also would have a large corporate portion and responsibility within the role. Several pieces of literature located in the Canadian Nurse during the 1960s speak to not only the changing role of

the Director but also the nursing supervisor and head nurse. Benne and Bennis (1961) discuss role confusion and conflict in nursing and how these were related to continuing and accelerated changes in the health field. “When change is uneven, conflicts and confusions in professional roles are bound to occur” (p. 126). It was also noted that nurses’ promotion to higher positions was not always welcomed as this usually meant a movement away from what they considered “real” nursing, away from direct patient care and from the sense of personal service that accompanied it (Brookbank, 1964).

Richmond gave several speeches on the role of the director of nursing and how it had changed over time. She prepared a speech for the Institute on Nursing Service Administration for the Quebec Hospital Association in November of 1960. Richmond stated that the role of the Director of Nursing was to provide freedom and leadership for the nursing department to provide nursing care. “The job of the Director of Nursing is not to be an expert nurse but as the department head she needs to know, recognize, and be free to set standards for good care and she must be given the responsibility and the authority to set and maintain standards of nursing care” (Richmond, 1960, p5). Richmond’s second point in her speech was that if the Director is to do the former than she needs to be given the authority to do it. This means she required the authority to manage a budget that enabled her to oversee the preparation of nursing personnel, employ staff as required, have control of expenditures for supplies and equipment, and as nursing makes up the largest portion of the hospital staff the director should also have a role in the overall administration of the hospital. “If the Director of Nursing is to function, not only as a department head, but also as a senior administrative officer then she must be made a part of the senior management council” (Richmond, 1960, p15).

The second speech that Richmond gave regarding the role of the Director of Nursing was entitled *Two Hats---is it possible* unfortunately there is no evidence of who the speech was given to or in what year, but it likely was given around the same time as the previous one discussed. Richmond described the two sides of the director's role being both an executive and a consultant to staff. It is important for the director to not just be the authority figure issuing directives but to also be the consult who offers expert advice to fellow practitioners. These two roles must be reconciled " if the director of nursing is to become a leader who can both attract desirable candidates in the profession and develop a growing staff who will become the kind of people who can give expert, understanding, patient-centered care and who will find increasing personal satisfaction in nursing" (Richmond, no year, p5). Richmond's speech shows us that she believed the director of nursing must adopt a problem solving approach to clinical situations encouraging staff to think through the issues and reach to outside resources in order to solve them. She felt it was important to create an atmosphere where staff members were comfortable with asking questions and with making mistakes. She also felt it was important for the director to listen to the staff and try and prioritize solving problems as the staff members see them rather than how the director sees them. It could be encompassed by stating it was important to create rapport within a group and utilize the group approach when dealing with issues. Finally, Richmond pointed out that the director needs to consider herself a student as well, in terms of approaching situations as a learner, open to advice, and eager for teamwork thus allowing staff to see her not only as an authority figure but as a consultant, teacher, advisor, and helper as well.

New Zealand

Her professional roles as director, educator, and leader showed Richmond's passion for looking towards the future of nursing and making the necessary changes to improve nursing

education and nursing care. Her leadership and dedication to nursing education was even recognized around the world. In 1974 Richmond was awarded a Dr D.P. Kennedy travelling fellowship. “The fellowship, administered by the Nursing Education and Research Foundation, honoured a former Director-General of Health in New Zealand. The late Dr Kennedy was well-known for his interest in the role of nursing in health services” (Auckland Star Newspaper, March, 1974). Richmond visited New Zealand and spent a month in the country visiting different hospitals and associations in several cities acting as a consultant on the transition of nursing education from hospital based programs to one in the field of general education. She shared with nurses, administrators, educators and other interested people her experiences in maintaining nursing services during the education transition period. During her time in New Zealand, Richmond discussed many issues but the first message she conveyed was that strong professional associations were needed to provide governments with information, ideas, and guidance around nursing education, evaluation of nursing services, and around how nurses are utilized in the health care system. Secondly, Richmond emphasized the importance of looking outside of the hospital walls to where the future of health care was going. Western world trends in medical care were steering toward development of community health centers, clinics and caring for people in their homes, she noted. “One of the reasons for changing the training of nursing from hospitals to the general education system is that the whole field of community health services is broadening and tomorrows nurse must be able to understand a wider range of work than today's. The nurse who trains at an educational institution will gain practical nursing skills in a wide variety of environments because it is in such a variety that her work will eventually lie” (The Southland Times, March 30, 1974). Finally Richmond pointed out how important it was to make the nurse training programs attractive to students and related to the

wider scope of work which the nurse would undertake in the future. “Married nurses must be encouraged to return to the profession, there must be a greater selection of learning experiences for the students, and nursing must return in part to its care oriented services rather than its procedure oriented services” (Richmond, The New Zealand Nursing Journal, June 1974, p. 9)

Richmond’s time in New Zealand was a great opportunity for her. Her expertise was called upon. Her leadership was well-respected internationally, and she offered valuable insights on how the transition of nursing education needed to unfold. Richmond’s experiences in New Zealand re-emphasize the changing nature and place of nursing practice over the years.

Summary

During the 1950s, 1960s and 1970s when Richmond held several professional roles as director of nursing education at RJH and director of nursing at RJH and VGH there were many complex nursing service and nursing education situations arising. Richmond and her colleagues were collaborating to examine the complexities and address them. Issues such as how nursing education was structured within training schools; advancing technological changes; and the fluctuating workforce of qualified nurses were impacted significantly by several cultural, economic and political influences. Richmond and her colleagues had to examine and discover new ways to educate nurses and provide nursing services to the public by addressing the effects of the Second World War on the economics of the nation and on the nursing workforce. They also needed to find ways of adjusting to the growing demands for hospital based care as a result of a nationwide health insurance program and the increasing public demand for highly efficient and technically competent nurses to provide the care required. It was a time of significant change in the service that nursing provided and in how nurses were trained and educated. In the proceeding chapter I will build on this by discussing Richmond’s involvement in several

professional associations as well as the work she did giving speeches to several associations and conclude with a discussion on her final years as an instructor at the University of Victoria.

Chapter Five: Mary Richmond's Political Influence

Professional Associations and Speeches

Throughout Richmond's career she belonged to and participated in professional nursing organizations and was invited many times to give speeches, commencement addresses and be the keynote speaker at several functions as a recognized nurse leader. The textual records that are located in the BC History of Nursing Society's archives contain many of the speeches that she gave and provide great insight into Richmond's thoughts and opinions regarding not only nursing and nursing education but ethics, labour relations, role definition and research. The analysis of these speeches not only enlightened me to how well-respected and thought of by her peers Richmond was, but also how she was a driving force for nursing moving forward. In this chapter I discuss the speeches she made in order to find the common thread and themes of Richmond's opinions as well as current nursing issues of the times. I conclude with a discussion of Richmond's time as an instructor at the University of Victoria where she spent her final professional years as a nurse.

1950s

The 1950s were a time of restructuring of health care in Canada. The public was demanding a higher quality of care delivered within the walls of hospitals, which they perceived as purified denizens where experts with great knowledge treated their ailments and made them better. The papers Richmond wrote reflect societal as well as nursing issues during this time. In the following archival papers Richmond captured the points of increasing hospital efficiencies through the movement of nursing away from the caring personal relationship with patients towards a system of memorizing steps and performing skills "on" the patients rather than seeing the patient as a whole person and caring for them accordingly. Unionization was also a growing

movement during this decade and the overall message of Richmond's papers are around nursing's attempt to balance the need for better working conditions with the ideals of professionalism.

During the years Richmond spent at McGill University she wrote a paper for a Scientific Management course entitled *Labour relations and the professional nurse employee* (Richmond, 1950). The founding father of scientific management theory is Frederick W. Taylor (1856-1915). He was an American inventor and engineer. The theory seeks to improve an organization's efficiency by systematically improving the efficiency of task completion utilizing scientific, engineering, and mathematical analysis. The goal is to reduce waste, increase the process and methods of production and create a just distribution of goods (Calareso, 2014). Taking a course in scientific management was significant for the time as scientific management theory was an important emphasis in hospital management. McPherson (1994) described how "the influence of scientific management on nursing procedures in the interwar period is clearly evident. Each feature of nursing practice was subdivided into its component steps and students were drilled in the precise execution of each step" (p. 80). The goal in health care was to increase hospital efficiency which included the organization of nurses' work and was a strong scientific influence in shaping nursing service and education.

The paper clearly outlined Richmond's opinion regarding the disadvantages of professional associations being affiliated with labour unions; she also included an overview of the work of the labour relations committee of the Registered Nurses Association of British Columbia. Richmond stated in her introduction that her intent in the paper was to point out that sound personnel practices are necessary for professional employees, that labour unions methods and motives do not satisfy nurses needs and are not in harmony with the accepted characteristics

of the profession, and that the profession can evolve for itself a bargaining procedure without loss of professional status. Bates, Dodd and Rousseau (2005) describe how despite ongoing discontent with nurses salaries and working conditions, hospital staff nurses were slow to accept unionization as they were trained in a tradition of dedication to service and loyalty to the hospital. “The idea of putting the needs of oneself ahead of patients’ and possibly withholding services to enforce demands seemed at the very least during this time unladylike, if not downright unethical” (Bates, Dodd & Rousseau, 2005, p. 214). The issues of unionization versus professionalism continued well into the 1970s. Kealey (2008) discussed how due to consistently low wages and poor working conditions nursing associations across Canada, in particular New Brunswick, began to explore the potential for collective bargaining. As other public sector workers began to unionize and make gains, nurses gradually came to accept the idea of unionization even though the nursing workforce still held to the core values of service, the needs of the patient, and subordination to doctors (p. 6).

Richmond’s opinion is clear, one cannot be a professional within a profession and be engaging in and associated with the methods and aims of labour unions. Richmond listed several disadvantages for the nursing profession to be associated with labour groups. First off nursing in hospitals did not have a real management-labour division. Nurses in Richmond’s years were both employers and employees and they all shared the same goal of providing health care services to the public. After the Second World War, labour unrest was increasing and unions sought out nurses in order to help them but Richmond felt it was more about increasing union membership and fees then around fighting for the rights of nurses. In fact, unions often barred from membership any nurse above the rank of head nurse which at the time included supervisors, instructors, and department heads who were also nurses (Richmond, 1950). This discrimination

served to divide rather than unite nursing staff. In 1973 the Supreme Court of Canada in *Service Employees International Union versus Saskatchewan Registered Nurses Association (SRNA)* agreed that the SRNA “could not legally represent staff nurses in Saskatchewan because of management domination. This decision led to the separation of professional associations and unions across the country” (Ross-Kerr & Wood, 2003, p. 302). The second disadvantage that Richmond points out is the dichotomy of nursing values; founded on a tradition of public service with a social consciousness and obligation seemed in contradiction with labours’ demands for increased wages, better working hours and conditions, and somewhat lack of regard for public welfare. Richmond’s third point is that labour unions are short-sighted looking out only for their personal conditions of employment and cannot see the implications of broader social issues which are essentially what the nursing profession must do. Finally, Richmond stated that labours’ advancement based on length of service is not a sound way of promoting staff within a profession. Nurses have many other qualities that prepare them for advanced positions including added preparation and experience in other fields as well as personal characteristics. Richmond clearly believed that while job security is important it must not be secured at the possible cost of professional interests or even harm to a patient.

As an alternative to nurses belonging to a labour union Richmond discussed the advantages of the Labour Relations Committee of the RNABC. Initially, in the 1940s professional associations also took on the function of bargaining for its members. Zilm and Warbineck (1994) explained that RNABC formed a committee in 1943 to look into socioeconomic matters and then in 1946 they set up a Labour Relations Committee as demanded by the then new Labour Act to negotiate collective agreements with individual hospitals and agencies. In 1946 the RNABC was the only provincial nursing association who had attained the

ability to bargain on behalf of its members and as a result many gains were achieved including increased salaries and vacation time, the 40 hour work week, yearly pay increments, grievance procedures, and a voice in working conditions. Richmond stated in her paper (1950) that all nurses within the province of BC belong to the RNABC and as such its voice will be stronger and because it is a professional group its demands will bear in mind general public welfare. The personnel policies allegedly would provide for the individual growth of members, encourage advanced preparation for higher positions, and were concerned with professional standards, attracting more people to nursing, and enabling the population to secure more adequate nursing care. The RNABC continued to bargain on behalf of its members for several decades. “In 1959 the RNABC agreed to a proposal by the BC Hospitals Association for province wide collective bargaining. This meant that all eligible nurses in the hospital bargaining unit were covered by one collective agreement and by 1967 RNABC was certified as the bargaining agent for 13 public health agencies, several clinics and a medical insurance company” (Bates, Dodd & Rousseau, 2005, p. 215). As evidenced by her paper Richmond truly believed that job satisfaction was not just about the fulfillment of contract terms, (the tangible benefits that might be obtained through labour unions), but also about the intangible benefits such as personal interest in employee welfare, opportunities for advancement, provision of educational programs, and an increasing sense of loyalty to the institution and the profession which comes with incorporating labour relations with a professional organization such as the RNABC.

Prior to becoming the Director of Nursing at the RJH in Victoria in 1956 Richmond completed her Master of Arts degree at Columbia University. During that time she wrote a paper titled *Assignment A0-1* (Richmond, 1956). In the paper she outlined her thoughts in regards to the change required in the directorship at the hospital and the change required on behalf of the

staff in relation to their expectancy of the director of nursing. In essence she discussed role definition and change management in the relationship between staff members and nursing leadership. She stated that change can occur through the identification of her role as the Director of Nursing, an evaluation of the situation within which change is to be effected, and the establishment of specific goals. Richmond classified herself as an outsider in her role as director for several reasons but genuinely wished to be seen as a consultant rather than that of an authority figure and she endeavoured to do this by identifying herself to the group as a teacher and supporter, by becoming an expert in an area that had significance for the staff, and by being willing to use other experts both within and outside of the group. The issue of creating and maintaining a balanced leadership style, which Richmond and her peers endeavoured to achieve, remains an important aspect of nursing leadership in today's health care environment as well. In a current nursing text, *Nursing Leadership and Management*, for example, Searle-Leach and Doucette (2008) noted that nursing leaders must be lifelong learners with a thirst for knowledge and a desire to maintain and enhance leadership competencies. To effectively manage in chaotic and complex practice environments, leaders must be comfortable with and aware of the constant need for change, possess budget and financial skills, and remain committed to team building through effective management of personal growth. Searle-Leach and Doucette (2008) described many characteristics of a leader focusing on vision, passion and integrity but noted not only the "need for nurse leaders to have knowledge of nursing practice, but to also understand regulatory issues and business skills and to have an understanding of risk, liability, strategic planning and political acumen" (p. 154). Likewise, Richmond realized that in order for lasting change to occur it must be directed by the staff itself, not by the authority figure. She wished to evaluate the nursing situation at RJH and planned and developed a questionnaire for staff to complete

about their expectations of the director of nursing, their attitudes towards administration, and their willingness to become greater participants in a more collaborative based system. Becoming greater participants could be achieved by identifying common goals and establishing the issues to be addressed. Richmond quoted in her paper, one of her course professors, Kimball “those who share responsibility in common problems must be given the opportunity to work toward a solution”. Richmond felt it was her responsibility to establish a climate in which staff could express themselves and work towards identified goals; she would do this by setting up committees. Richmond believed that the morale of nursing staff would improve through participation in a worthwhile undertaking.

Upon returning from Columbia University and becoming Director of Nursing at RJH as well as the Chairman of the RNABC committee on nursing Richmond gave a speech at the BC conference on Nursing in April of 1958, entitled *Trends in nursing practice and the preparation of nursing personnel* (Richmond, 1958). Richmond’s speech outlined five trends in nursing that she had observed in her role as director of nursing at RJH. First she discussed advancing technology in the medical sciences and its influence on the changes taking place in nursing. Specifically, the moving away from nursing duties that were time consuming but allowed prolonged contact with patients allowing for the nurse-patient relationship to flourish and that was satisfying to both parties, towards treatments that are executed quickly and were more complex, uncomfortable, and hurtful. The nurse-patient relationship has fluctuated over the decades, initially with the nurse spending considerable amounts of time at the patient’s bedside attending to all of their needs. Then, as technology advanced and “medicine embodied the techniques of clinical examination, the process of diagnosis and the cognitive base of pathological anatomy, these new medical practices established the outline of a passive body and

an objectified patient” (Armstrong, 1983, p. 457). It was only after the 1960s that researchers started to look at the nurse-patient relationship including attending to not only the physical needs of the patient but also the psychological needs of the patient. Armstrong (1983) described how it was important for the nurse to listen and help the patient to communicate because interaction between nurse and patient was vital to the process of nursing and to the patient’s response to treatment. The second major trend Richmond discussed were the changes in patterns of employment including; greater numbers of practicing nurses; increasing number of employed nurses in institutions and a decreasing number of private duty nurses; a greater number of registered nurses being married; the implementation of a national health plan; and a greater opportunity for nursing employment outside of Canada; all of these a direct result of societal changes occurring post Second World War. Ross (2003) described four factors that led to the rapid increase in the number of RN’s during the 1970s and 1980s including increase in nurse employment in and out of hospitals, reduction in the bed-to RN ratio, reduced number of assistants, aides and orderlies, and the increase in the number of nurses working part time (p.235). This shows that the nursing workforce has fluctuated several times over the decades as a result of many factors.

The third trend that Richmond touched on was something she referred to as the “fractionalization” of nursing care which is the division of the patients’ care among a number of people. The total care of the patient is broken up along with shorter hospital stays, early ambulation, and the emphasis on early independence all which alter the pattern of nursing. Fractionalization decreased the amount of time nurses spent with patients and decreased the amount of time that nurses had to build bonds with the patients. The fourth trend is a change in disease patterns. As seen during Richmond’s formative nursing years (1950-70) people are

living longer resulting in increased chronic health conditions, increasing number of patients requiring major surgery, change in the pattern of pediatrics, and more emphasis placed on patients mental health issues. The final trend that Richmond discussed was the expectation that nurses play a greater role in total health care programs and in the broader community panning of health services. Richmond quoted Mrs. Isobel MacLeod a 1936 graduate of the University of Alberta who worked to support the professional nursing practice and was the president of the CNA from 1964-1966 (<http://ottawacitizen.com/health/seniors/nursing-pioneer-isobel-macleod-turns-101>). Mrs. MacLeod stated “you know that nursing is teaching as well as treating; that it takes place in schools, industrial plants, offices, hospitals and homes; that it serves the healthy as well as the sick and that is influences government as well as private citizens.” Not only did Richmond endeavour to identify the trends occurring in nursing but she also suggested that those trends would influence nursing education as well. This will occur though the need for additional and continual training on the advancing technologies in healthcare; through the redesign of educational programs to meet public demand; and through the examination of how nurses can function as both a competent, skilled technician while maintaining a close, caring personal relationship with the patient. Richmond noted that after her paper presentation there was a lively discussion and debate around the trends and issues of the time and it was agreed that future conferences would be valuable and desirable but that more time would be needed in order to explore the many aspects of nursing in which all participants were interested in.

1960s

The 1960s was a period of time when the majority of the transition of nursing education away from the hospital based model to the academic model occurred. One of the themes that emerged from Richmond’s writings during this time includes the restructuring or reassignment of

responsibility. Richmond described this in relation to the role of the director of nursing and how over time the role shifted from a focus on clinical work and oversight to a role that needed to have knowledge not just about nursing but about administration, management and the global health care perspective. Another theme that emerged was the concept of nurses being research minded. Research is an important aspect of any profession and Richmond felt that nursing needed to embrace it with greater purpose. Richmond also touches on the concept of specialization in nursing and its importance in the profession. The themes of resource allocation, advancing technology and the shifting place of nursing education are also concepts that Richmond touched on in her writing and speeches during this decade.

The majority of speeches that have been preserved were ones Richmond gave to a variety of organizations over the years in the 1960s. They encompass a wide range of topics from health care careers, to the role of the director of nursing, to research, to the quality of care. In 1960 Richmond was asked to prepare an address to the institute on Nursing Service Administration of the Quebec Hospital Association in Montreal. The speech is entitled *The task of nursing service and the role of the director of nursing* (Richmond, 1960). I have discussed this speech earlier in chapter two as it related to the professional roles Richmond held as Director of Nursing and Director of Nursing Education so will touch on it briefly here as one of the issues Richmond found important during her career. Richmond endeavoured to discuss not all that there is to know about nursing service and the role of the director of nursing but to share her thoughts on the subject. First off she felt that hospital administration and the director must find common ground in the expectations of their functions. She goes on to state that both of the formerly mentioned positions would agree that the role of the department of nursing is to provide nursing service but what exactly is nursing service? Richmond stated that nursing service functions not

only to provide bedside care, not only to provide comfort, and not only to perform technical procedures but to put into words and deeds that the patient is at the center of their own health care journey and there are some complex services they need such as technological advancements and some care needs they can do for themselves but that the nurse is there to assist them with their health care journey. Richmond felt that the job of the director of nursing was not to be an expert nurse but to know, recognize, and be free to set standards for good care. The director must be given the responsibility to set and maintain standards of care and if she is to do this then she needs to be given the authority to do it. Finally Richmond believed that the director of nursing role should not only include a focus on the nursing program but to be able to see and participate in the overall activities of the hospital. In order to fulfill this role the director will need more than just preparation in nursing but also advanced preparation at a university level providing a broad perspective of the health care system.

In April of 1965 Richmond participated in a panel presentation in Edmonton Alberta around the concept of nursing research, her speech is entitled *Why research in Nursing?* The idea that nursing practice should be based on research rather than tradition, ritual or intuition was not a new concept during the 1960s. Nurses, including Florence Nightingale, “viewed research as an integral part of nursing and believed that nursing practice should be generated from confirmed facts and epidemiological data” (Ross-Kerr & Wood, 2003, p. 137). However, the substantial development of nursing research in Canada as Boschma (2005) noted did not begin until the seventies along with the evolution of graduate education. Prior to the 1970s nursing research mainly focused on areas such as education, administration and staffing issues but as nursing specialization grew so did research about clinical nursing practice and patients responses to the nursing practice. In Richmond’s presentation she discussed what she believed research

means, offered a defense of it in nursing and identified some of the areas in which she felt that research was appropriate and needed. Richmond defined research as a purposeful, systematic and refined way of thinking. She discussed the process of how research unfolds and then moved on to her defense of why it is an important part of the nursing profession. Nursing had been slow to embrace research as part of practice and the profession for a couple of reasons; first off it can be seen as cold and technical, entirely in contradiction to the perceived belief of nursing as warmth and caring; and secondly because nursing was seen as a subservient profession of doing as one is told rather than as a self-directed profession. But in order to be a profession nursing must do research and respect it, part of this process involves assessing what research has been done in the past in order to build upon it. This must include supporting young nurses in preparing to do research and identifying significant problems that need to be examined and addressed. Imparting the sense of being research-minded is an important concept in creating an environment where young nurses incorporate research into their everyday practice. As Ross-Kerr and Wood (2003) note, in a research friendly environment, staff will begin to question their practice and systematically document the problems of greatest concern. This fosters a sense of accountability and professionalism, which itself leads to increased job satisfaction and lower staff turnover (p. 142). Finally, Richmond attempted to look at what areas needed nursing research. Richmond believed that if we are to accept that nursing provides a very specialized service in the health care system and is to reach professional status by having its own unique body of knowledge then we need to focus our research efforts on developing that body of knowledge and providing some role definition for the nurse. In addition, Richmond stated in her speech “if we agree with the concept of the unique function of nursing then we need to examine what we have done to distort the priority status which we have tended to establish in relation to

the various elements in nursing” (p.15). I believe she meant that if nursing is a unique profession then why does it continue to be a subservient position, how can the system be restructured to create personal satisfaction in nurses’ work and increase the status of nurses in the health care system? The second area Richmond identified that nursing should focus their research efforts on is to do research that will help the nursing profession further understand the large scale bureaucratic organizations in which nurses work in order to capitalize on the values and functional aspects and counteract their dysfunctional aspects. It remained important to determine how nursing could provide a personalized caring service within a large, political, bureaucratic system such as health care. Finally Richmond stated the importance of role definition for nursing which should be examined through a research perspective.

In 1966 Richmond was invited to participate in a panel for the Alberta Association of Registered Nurses on *Let’s Examine the Quality of Care* (Richmond, 1966). Richmond’s intent in her speech was to share a few of her beliefs and ideas around quality of care and in the process raise questions and debates among the participants in the hope of raising the quality of care in large health care institutions. She began by discussing the concept of care and concluded that care is not about cure but about extending oneself toward another and that the role of nursing essentially is supporting the patient in the maintenance of equilibrium in the physical, sociological and psychological spheres. Richmond then moved on to state that “we are moving closer to seeing nursing as a process rather than a series of disconnected and relatively isolated incidents”. Richmond believed that evaluation is an important piece in improving the quality of care and this can be achieved through accreditation, audits, and questionnaires for patients and staff allowing for a focus on specific aspects of care, the circumstances around it thus leading to an improvement and change in the care provided. Richmond goes on to describe how in order

to achieve quality care it is important to see that health care is on a continuum, that hospital care is not in isolation from other areas of health care and that there must be inter-agency collaboration in order to improve the care for the patient. Richmond's next point in her speech is around the concept of specialization. She states "it is generally accepted that excellence in a field develops with specialization, yet we in nursing have often expected each other to be all things to all people". Richmond is a proponent of the development of expert nurse clinicians, recognized professionally for their excellence and represented by a university degree. "The clinical nurse specialist is an advanced practice nurse who assumes the role of consultant and change agent in clinical practice, education, and research" (Wood, 2003, p. 149). The literature shows that the concept of a Clinical Nurse Specialist role began to develop with nursing becoming increasingly specialized. In fact, in 1971 the UBC and VGH schools of nursing set up a committee to explore new developments to education, the recommendations were for four integrated two year programs. The third year level would be preparation of a clinical nurse specialist with a master's degree in nursing in which the nurse would specialize in either hospital or community nursing with some sub-specializations (Zilm & Warbineck, 1994). Through this specialization Richmond saw in-servicing as being geared towards the development of excellence, where the content is significant in depth resulting in improved care of the client and a greater feeling of belonging and engagement in the health care process. In-servicing as Richmond described involved training provided to employees during the course of employment. The last two steps that Richmond offered as a way to improve patient care are by re-examining nursing's positions with the teaching-practice-research triad and by doing nurses' part to develop a care-centered collegial relationship with physicians.

In 1967 Richmond participated in a panel presentation to the BC Hospital Association. Her presentation was entitled *Training personnel to meet patients' needs*. She starts off her presentation by stating "I most sincerely believe that fundamental in meeting the needs of patients are the training of personnel to meet those needs". Richmond discussed four points in how to meet patient's needs. First off, hospitals must endeavour to meet the needs of patients through employing well-trained personnel. This entails hiring personnel who meet the qualifications of their professional associations ensuring that at least the minimum qualifications have been met giving co-workers, managers and administrators the confidence that they can entrust the care of the patient to the employee. Secondly, an orientation program and on-going in-service program must be provided because as nursing preparation moves towards a more overarching general education about principles rather than procedures onsite orientation will become increasing more important. Ongoing training will be needed due to the rapid changes in equipment and procedures and in order to enable staff members move forward in their careers. Thirdly, there needs to be encouragement of staff members to participate in training outside of the organizations they work for. These include their professional organizations as well as advanced preparations in the form of workshops or university courses as it enables the individual to embrace the commitment to lifelong learning and contribute to the improvement of patient care. The final point Richmond made is the importance of creating an atmosphere of change and improvement, where suggestions are welcomed and where research, learning and questions are respected.

In addition to taking part in the panel presentation Richmond also gave a speech during the meeting of the BC Hospitals' Association in 1967. She titled her speech *Nursing, What will I tell my daughter?* The convention focused on the decade ahead of them, the 1970s and

Richmond discussed what nursing service and education would look like in the decade ahead and what they could tell young people about the nursing profession. The first fact that Richmond stated was that there would be an increased demand for hospital personnel. Increasing population equals increasing need for hospital beds and services thus touching on the need to make nursing an attractive profession to join and to maintain recruitment as it is estimated that nursing will require one in five or 20 percent of graduates to choose nursing in order to meet service demands. The second fact was that there would be an increasing number of nurses and nursing students who are married and from non-rural communities. Training programs would need to be redesigned as they would no longer be geared toward the young, innocent, farm girl but to married middle class women with families and life experiences. The third fact was that nursing would continue to grow in its diversity and ‘we cannot expect that the one nurse can continue to be all things to all people’ (Richmond, 1967, p. 5). As a result basic education should be the rule of thumb for all nurses and then allow them to specialize in their clinical area of choice. The final fact that Richmond mentioned was that nurses would be mobile. There would be a continual movement into and out of the nursing labour market due to marriage, children, transfers, vacations, and foreign nursing opportunities. This was certainly evident in much of the literature including Ross’s (2003) chapter on the nursing workforce pendulum where she described the remedies for the difficulties of recruitment of nurses and for the problems in salaries and working conditions. She stated, ” it depends on the recognition of the nursing profession, on the autonomy of nursing practice, on their educational requirements and on their enormous and distinctive contribution to the health system” (p. 230). The question that Richmond posed to the BC Hospital Association’s delegates was, given that many of the above factors are out of nurse’s sphere of influence, which factors are they able to influence in order to

guide the nursing profession in the right direction. Richmond goes on in her address to discuss the role conflict in nursing and how that can cause “dis-ease” and lack of job satisfaction. “The conflicts of care versus cure the feminine versus the masculine and the dichotomy between what has been called the Mother Surrogate versus the healer role is an important issue to keep in mind when developing and transforming nursing education and service systems. Inherent in professional status is the ability, indeed the responsibility to make independent nursing judgements which are based on an intellectually sound assessment of a situation and clinical reasoning. In medicine this is called a diagnosis but I would state that nurses also make such judgments continually on a daily basis as well” (Richmond, 1967, p. 11).

Over the years as a result of nursing shortage issues, increased use of technology, and high patient acuity it has become essential that nurses are able to make complex decisions sometimes under conditions of uncertainty and risk. Simmons et al (2003) observed that “clinical reasoning is an essential component of professional practice and guides the nurse in assessing, assimilating, retrieving and/or discarding components of information to make decisions about patient care” (p. 702). It is clinical reasoning that distinguishes and sets apart the professional nurse from other ancillary health care workers. It is important that we, as Richmond well outlined, not just see ourselves as carrying out skills, tasks, or duties but use our knowledge base, insight, and judgement to assess any given situation and make decisions based on our assessment. Richmond believed that one of the problems for nursing during these years was to somehow reconcile the role of the professional person with the necessity of functioning within a very large organization. Richmond concluded her speech with a discussion of administration and how administration in the 1960s and 1970s was referred to as the “conceptual era”. The job of an administrator she argued was not only to define how the jobs should be carried out, not only

to ensure that the workforce has job satisfaction, but to see the operation of an organization within the total context of the communities which it serves and which serve it. Richmond concluded with stating “ If we could basically answer some of these questions we would be in a better position to answer the question which I know is uppermost in the minds of most people in the hospital world today and that is where should nursing education find itself and of what should nursing education consist?” Richmond is pointing out that nursing leaders and administrators need to be progressive in their thinking and in the changes needed in moving the profession forward.

In 1967 Richmond was invited to speak at a CNA regional workshop for Directors of Nursing Service in Hospitals that took place in Regina Saskatchewan. She titled her speech *Improvement of nursing services through the problem solving method*. For decades researchers have attempted to gain an understanding into how nurses think and how they problem solve while providing client care. Taylor (2000) reviewed the literature of several decades looking at how individuals problem solve. She described the difference between the nursing process; a method of problem solving for the purpose of care planning and the problem solving method used during care-giving activities. Taylor (2000) discovered through her research that “no single general model of clinical reasoning exists, however a small number of strategies appeared to be used consistently by nurses to problem solve” (p. 848). Nurses developed a hypothesis in the initial client encounter and then used general questions to seek out information before asking more specific questions that would assist them in helping to problem solve with the client.

Richmond began her speech by admitting she was in a terrible dilemma but realized that it was not her task to come up with the answers but to identify some of the very real problems and issues with which the directors of nursing must come to grips with in their attempts to

maintain nursing services in their organizations and particularly those issues which lend themselves to the problem solving approach. First off, Richmond discussed several societal issues that were influencing all of the service professions. She talked about rapid sociological change that were occurring with changes in age distributions, rural-urban groupings, changes in patterns of illness and rising expectations for health and education. For several pages Richmond discussed the issues of nursing specialization and then of bureaucracy and how it is important to look at to what extent does the system of rules and regulations take precedence over the personalization of a service based on the individual judgement of the professional practitioner. The next major issue discussed that was a deterrent to the improvement of nursing practice was the clinical and geographical “hoboing” of nurses. Richmond felt that it was important for the directors of nursing to find ways for nurses to feel that they play a meaningful role in the health care system, that they feel a sense of belonging even within the impersonalization of large bureaucratic organizations. One of the suggestions made by Richmond in relation to staff retention was to offer opportunities for professional development and on-the-job learning. This remains a relevant issue in today’s ever increasing fast paced system. In today’s nursing world employee engagement continues to be an important topic. Spence-Laschinger and Finegan (2005) for example note that staff nurse empowerment has an impact on nurses’ perceptions of fair management practices, feeling of being respected in their work settings, and their trust in management which ultimately influences their job satisfaction and organizational commitment. Finally, Richmond concluded by touching on the issue of communication among health care disciplines. This issue is crucial to providing client centered care and ensuring the clients health care journey is seamless through transitions in care.

A critical perspective is provided by Richmond in her 1968 speech to the National Association of Hospital auxiliaries entitled *Who Cares*. She began her speech by stating “as nurses and as members of the auxiliaries to hospitals we represent the two groups of women most concerned about hospitals and about the hospitalized patient”. This paper dealt with the topic of who cares in two areas, first, who really cares for and about the hospitalized patient? Secondly who cares about health services, how they should be organized, financed and delivered? Historically hospital or women’s auxiliaries were volunteer organizations, independent from the administration of the hospital but providing services such as “fund-raising, running gift shops, and providing assistance with patients” (Handy & Srinivasan, 2004). Most hospitals including VGH had a women’s auxiliary to provide these services and they were an important part of the clients health care journey and of the functioning hospital, thus it was important for Richmond to address them and discuss with them her thoughts and opinions around the care of the patient. Handy and Srinivasan (2004) describe how as health care costs rose, an important cost attractive resource for hospitals is the use of volunteers in providing services to improve the quality of care such as, providing information as well as emotional support and reassurance for patients and their families. Richmond discussed the concepts of care versus cure and the importance of having a balance of both in practitioners and in health services. It is also important to keep in mind that the patient should not lose the sense of being cared for in the process of being cured and the practitioner should not become so cure oriented that they lose the capacity to care. This involved ensuring that educational and health care programs and practices are structured in a way that recognizes and rewards health care professionals for both the caring and the curing aspects of their work. The second part of *Who Cares* focused on health care services. Initially hospitals were founded on the sentiment of Christian charity, those with more

providing for those with less. This concept however changed as the cost of therapies grew and health care services came to be regarded as an inherent human right. Hospitals are competing not only for the gift dollar but for the tax dollar and as Richmond felt and stated in her speech “our concern must involve in the best sense, political influence: we must endeavor to influence public decisions in the ways we believe are in the public good. We need to raise public interest as well as private funds”. Richmond’s emphasis on the nurses’ role in politics is an important point. The nursing profession have not always expressed their opinions in the political arena, due in part to a sense of powerlessness and a belief that expressing their views will not be useful because they will not be heard. However, it is important for nurses, who are the largest group of health-care professionals to understand that as a group they can wield considerable influence to lobby governments for their objectives. Ross-Kerr (2003) stresses the importance of nurses developing political skills not only for use in nursing practice but in other areas of society where decisions are made. “The ultimate reason for enhancing the nurse’s political power, be it in the workplace, community, government, or professional organization, is to improve the health care that clients receive” (Ross-Kerr, 2003, p. 247). Richmond’s final thoughts regarding the hospitals’ auxiliaries were to pay tribute to their contributions and hope that they would continue to structure programs to meet the changing societal needs.

1970s

Nurses have always been faced with ethical dilemmas and have had to make ethical decisions but as health care increased in complexity the decisions nurses had to make also became more complex. Ross-Kerr and Wood (2003) note that there are many factors that contribute to the complexity, including the rapidly expanding body of knowledge about health and illness, and the development of new technologies to save or prolong human life. The

underlying message of Richmond's following speech includes the themes of technological advancements as well as nurse specialization. These changes in nursing service influenced not only the day to day decisions nurses made in practice but also influenced the greater ethical issues that nursing faced during this decade and were preparing to face in the future.

From the 1970s one speech has survived. Richmond spoke at a symposium at the University of Victoria in 1978 titled *Living and dying- ethics and technology*. By 1978 Richmond had retired from her position as Director of Nursing and had taken on a new leadership role in the emerging academic nursing program at the University of Victoria. This speech likely was given in the context of this new role. Richmond was part of a panel at the symposium and began by saying that she had not found answers to all the questions but attempted to give the questions a clearer focus and hopefully make it possible for them to be shared with others who help nurses in the health field. The questions Richmond proposed that need to be addressed were first off what are health professions attempting to do in and for society, are we health centered, care centered, cure centered, life centered or anti-death centered? Secondly, Richmond noted whatever the approach, is it a local or a global concern? Finally, what is medical technology? Richmond found that health care ethics are closely tied to questions of resource allocation. When financial and human resources are limited, making decisions about where to allocate those resources would involve making ethical decisions. It is important to be aware that with increasing advancements in technology and the ability to sustain life, perhaps beyond its natural limits, nurses need to endeavour to keep the health care decision making in the hands of the patient not in the hands of the health care personnel.

University of Victoria

In 1974 Mary Richmond returned to Victoria after resigning from her role as Director of Nursing at VGH. RJH offered Richmond a newly-created position as Director of Educational resources. “The establishment of this post enable most educational programs in the hospital to come under the control of a central administration and the schools administrative responsibilities were transferred from the director of nursing to Richmond in her new role” (Pearson, 1985, p. 159). From 1974-1982 when Richmond was the director of educational resources; RJH was making decisions about the future of its school of nursing. When the decision was made to phase out the school of nursing at RJH Richmond played a key role, not only meeting with other stakeholders in an effort to develop an alternate basic nursing education program for the community but Richmond also had to administer the new curriculum at RJH required by RNABC, plan reductions of students, faculty, and staff all the while maintaining a quality education for the students still at the school (Pearson, 1985).

The province of BC had initially encouraged the formation of a school of nursing at UVIC in the early 1970s but by the time it was ready to be developed the government of BC had changed and with it the enthusiasm and the money to move forward. Nurses from all over the province lobbied aggressively to move the development of the school forward and Richmond was a key cohesive force for the diploma RN’s both in Victoria and other parts of BC in the development of a baccalaureate program at UVIC; she of course already had experience with this type of program at McGill. In conjunction with Richmond’s appointment as the director of educational resources at RJH and as a leader in nursing and nursing education she was sought after by the University of Victoria and worked as a nursing consultant to the university office of academic affairs for two years as the university worked on developing its school of nursing.

“The UVIC School of Nursing like those at other universities wanted to include several university disciplines, new research, the systematic analysis of nursing, and the development of the nursing profession in their training” (MacPherson, 2012, p.54). Richmond had a consultant role at UVIC which included proposing a first year curriculum, preparing appropriate publicity and application forms, advising potential nursing students of course selection, determining steps for accreditation, and to generally assist the university in planning of the nursing school until a director of the school could be appointed and available on campus (Mary Richmond Fonds, Series 4 no. 3). It speaks to Richmond’s strong leadership that she energetically took on these two roles, each very demanding, and as such made a major contribution to the expansion of academic nursing education in BC.

According to J. Mantle (personal communication, November 3, 2014) the UVIC School of nursing started out with a very traditional curriculum under its first director Isabel McCrae; focusing on rehabilitation and gerontology. Courses from the 1950s that were standard across Canada were introduced in the UVIC program including teaching and learning, nursing administration, and nursing research. As the UVIC School of nursing grew the courses also grew and changed with the changing requirements of the nursing profession. When Mantle started teaching at UVIC changes to a more modern curriculum were already underway. Mantle taught a course in nursing concepts that was designed to help increase the diploma nurses’ critical thinking abilities. In the 1980s UVIC moved to include distance education as part of its program. Mantle (personal communication, November 3, 2014) recalled the start of that initiative. Courses were developed for the Knowledge Network and were given live by the UVIC instructors at the television studio in Victoria. Richmond, whose specialty was nursing administration, also participated in this distance education initiative. Eventually UVIC

developed its collaborative program with several of the colleges in BC. In 1989 after several years of discussion and significant work Cariboo College (CC) initiated its post RN BSN program in conjunction with UVIC. This initiative met the objectives of both UVIC and CC by allowing for educational upgrading for RN's outside of the lower mainland, by allowing students at that time enrolled in the CC RN program to continue to degree completion, and by allowing the development of an integrated four year baccalaureate nursing degree program in conjunction with UVIC to be implemented in the future (Simpson & Abbott, 2010).

Jessie Mantle was both a student and colleague of Richmond. Mantle (personal communication, November 3, 2014) remembered when she was making the decision to move to Victoria to teach at UVIC in 1980 that Richmond was already on faculty and encouraged Mantle to consider carefully, moving to the UVIC program because at that time the UVIC School of nursing was not part of a health science faculty. The discussion Mantle had with Richmond made her realize that Richmond understood the cultural milieu in which she taught. In the conversation I had with J. Mantle her final words about Richmond really resonated with me. "Mary was always oriented to the real world of patients; she felt you went to school in order to improve the world of practice" (J. Mantle personal communication, November 3, 2014).

Summary

Richmond spent the last phase of her professional nursing career as a professor 1976-1988 and acting director 1991-1992 at the University of Victoria. Richmond's dedication and leadership to nursing education and nursing service is evident in the archived material obtained from BCHoNS, CRNBC, VGH and UVIC. In 1998 a series of lectures given by UVIC faculty members were combined into a monograph and "were affectionately named the Mary Richmond lecture series to show an appreciation for Richmond's contribution to nursing as a nurse

administrator and nurse educator. We dedicate this monograph to Mary Richmond with thanks for her pioneering work as a moving force in recommending that education of nurses become part of a university system, and for continuing to work to ensure that health agencies and the university remain strongly connected” (Storch, 1999, in Banister, 1998, p.5).

Chapter Six: Conclusion

Summary

The question about how to best prepare nurses for practice by means of nursing education remains an ongoing area of attention and study. As circumstances of health care change, the issue of how to best structure nursing education remains. The purpose of this research was to explore the shifting place of nursing education in the 1950s, 1960s and 1970s. This purpose was achieved using a biographical examination of the life and career of Mary Richmond and looking at this transformation through the biographical lens of her career. This examination included questions surrounding how Mary Richmond and her peers perceived the impact of the move of nursing education from hospital based programs to the university setting on the preparedness of nurses and on patient care, and how Richmond's leadership positions shaped her views on nursing education. This research also included the question of what issues and events were occurring during this time period in BC that influenced the transitioning of nursing education. I also asked whether these changes were reflective of what was happening in the rest of Canada. The study utilized historical analysis incorporating the biographical method of inquiry to provide a framework for the project and allowed for an examination of the above questions. Primary sourced archived material as well as secondary sources were used for the historical analysis. It is through the exploration of Richmond's career and experiences that I discovered several social, cultural, economic and political issues that occurred in the decades after the Second World War that influenced the transitioning of nursing education.

Although the initial intent for nursing education in English-speaking Canada in the late 19th century was to mirror it after the British "Nightingale model" the influence of United States' schools of nursing was substantial. The initial leaders of Canadian schools of nursing lost the

autonomy to have sole directorship of the schools and this led to the expansion of hospital based nursing training schools in Canada. Richmond graduated from one such school, the hospital based nursing school at VGH in 1943. For Richmond, attending VGH enabled her to achieve her goals twofold. As a young woman who grew up during the Depression she was looking for a career that would provide her with financial security and align with her strong social democratic values. In Richmond's eyes nursing could provide her with both of these goals as it was a profession of helping individuals and society and it was also a profession that at the time was in great demand.

Societal changes during as well as after the Second World War such as expansion of women in the workforce and the changing needs and demands of society affected the nursing profession in terms of resource allocation and the changing role of the nurse in the health care system. These shifts in demographics and resources also influenced change in nursing education programs. Nursing leaders had to adapt and restructure the programs on a continual basis in order to keep abreast of the advancements in technology, the re-assignment of responsibility between health care staff and professions, and the movement within the nursing profession.

Richmond's career goals of advancing her own education, being a part of progressive change in nursing education, and leading developments within hospitals resulted in her moving back and forth between administrative leadership positions in hospitals, leadership positions in schools of nursing and advancing her own education at universities such as McGill University and Columbia University. This study shows Richmond's leadership in multiple contexts and the connections she made between education and practice. In reflection, Richmond's career also parallels the trends occurring in nursing and society during the decades after the Second World War. In her role as a director of nursing in a large hospital Richmond and her counterparts in the

nursing profession at large were attempting to balance the educational needs of students with hospital service demands. They did this through innovations such as the block system of nursing education, as well as finding other new and innovative ways to recruit, educate and train nursing personnel to meet the demands of the public, the expanding health care system and advancing technological changes in health care.

The fluctuation of nursing resources is a common theme throughout the history of nursing but became more evident during and after the Second World War. The influences on the shortage of nurses were many and varied. The large numbers of nurses who signed up for active service in the Second World War, the expansion of hospitals and the development of national health insurance all played a role in the changeability of nursing resources. After the Depression schools of nursing needed to make considerable changes in the numbers of students they accepted into the programs, the courses offered, and the structure of the nursing programs in order to meet growing demand.

The population increases after the Second World War, the changes in the public's perception that health care was a right, and the expansion of public health insurance greatly impacted nursing service and education. It was an age of "industrialization" in terms of health care as hospitals were expanded, new ones built, and caring for the ill occurred more and more in the hospital setting and less in the home or community setting. The new hospitals required an increased number of nurses to staff them and while this increase expanded career opportunities for nurses it also affected the hospital schools of nursing. While students were still being used to staff hospitals in the late 1950s to early 1960s there was increasing agreement across Canada that nursing education programs needed to be incorporated into the college and university system. "It was believed that students required broader learning opportunities than was possible in single

purpose education agencies operating in association with hospitals” (Ross-Kerr, 1998, p. 55).

This shift in demographics and perception meant that the place where nursing service was provided as well as where nursing education was provided were both in a transitional stage.

With the increasing demands upon the nursing profession, directors of nursing and administrators of hospitals began to look at expansion of the health care team by incorporating new auxiliary personnel that could take on some of the duties formerly done by registered nurses. In Richmond’s role as director of nursing at RJH and at VGH she incorporated several new initiatives in order to meet growing service demands. These included the hiring of unit clerks, incorporating nursing aides into ward service and encouraging married women to return to the nursing workforce. This assessment of re-assignment of responsibility from not only physician to nurse, as technology advanced, but from registered nurse to licenced practical nurse and then to care aide and ward clerks as well as other members of an expanding health care team including lab technicians, physiotherapists, and x-ray technicians generated a collaborative era in health care. In addition to the changing role of the registered nurse the role and responsibility of nursing leaders such as the director of nursing also changed over the decades. With health care expansion these nursing leaders had to take on duties and responsibilities in addition to their clinical role and over time the role merged as one of manager, supervisor, teacher, and direct patient care nurse. Richmond’s unique position within the nursing profession, having experience as a director of nursing service, director of a school of nursing, and as instructor positioned her well to function effectively in this ever expanding role. It is Richmond’s unique perspective that I believe allowed her to gain a greater understanding of the nursing leadership profession and to be able to flourish as a director of nursing while maintaining a commitment to a collaborative system (Richmond, 1960).

The committees that Richmond belonged to and the speeches she gave over three decades illustrate not only her thoughts and opinions but bring to the forefront many of the important issues and themes in nursing that have been discussed in the body of this paper, as well as her activism and political influence. Richmond's discussion of the emergence of the labour movement for example shows the influence of unions over a workforce who were advocating for better working conditions. Richmond's opinion regarding the nursing profession being associated with labour unions was clearly defined; the methods and motives of labour unions were not in harmony with the values and beliefs of the nursing profession. Her discussion also highlights the high value leaders within the nursing profession placed on the concept of professionalism and the efforts that nursing had to undertake in order to be recognized as a profession and the effort it took to balance professionalism with activism.

Richmond's discussion of nursing education's future shape and structure is another example of an important theme that was discussed in this thesis. With the significant changes occurring in Canadian society during this time period Richmond emphasized the importance of forming nursing education programs that were attractive, flexible and comprehensive. With advancements in technology and nursing research Richmond encouraged other nursing leaders to establish nursing education that focused on training students to provide care using a holistic perspective, to offer basic nursing education that would prepare students to work in any area of health care, and to provide opportunities for specialization. Richmond and her peers hoped these advancements in nursing education would address the issues of resource allocation, improving patient care, and strengthening collaboration among health care professionals and agencies.

In her speeches Richmond touched on many of the shifting trends in nursing in the three decades from 1950-1980 such as nursing resource allocation, advancing technology, changing

demographics of society, re-assignment of responsibility, and the shifting place of nursing education. These trends are brought to light through Richmond's work and have illustrated her thoughts and opinions about the importance of nursing education being housed within the college and university model. The archived material has also shown Richmond as a proponent of the importance of advanced education for nurses in leadership roles, the importance of expanding the concept of specialized nurse education, and the ongoing importance of encouraging an environment where nurses will strive to be lifelong learners. The examination of the primary and secondary sourced material has shown Richmond's significant place in the transformation of nursing and nursing education in BC from the 1950s on.

Contribution to Nursing History and Areas for Future Research

The findings of this study are important as they add to the nursing history literature and to nursing knowledge about the transformation of nursing education from 1940 to 1990. The analysis presented in this thesis contributes to a greater understanding of both Mary Richmond's career and the transformation of nursing education post Second World War. This study points out that the transformation of nursing education was vital in bringing the profession to a place where a complex knowledge base is valued and the profession is based on standards of practice. This further supports the work of Ross-Kerr (1998) on the evolution of the nursing profession in Alberta. This study also adds to current research describing the societal influences on nursing education. The Weir report (1932) made recommendation for changes to nursing education. These included having the authority for operating schools of nursing rest in the general education system and that nursing education should be comprehensive, focusing on learning and grounded in the science of education. It took many years however before Canadian nursing schools began to make the necessary changes. This study confirms Kirkwood's (2005)

research that the evolution of nursing education did not happen overnight but was a long process influenced by advances in medical science, introduction of hospital insurance, and increased government funding to health care and education. Boschma's (2005) discussion of Margaret Scott Wright gave context to this study by providing an additional perspective on a nursing leader in the decades after the Second World War. Similar to Scott Wright's career, Mary Richmond moved between nursing administration and practice, and education. This movement occurred due to Richmond's career aspirations and as a result of the growth in the nursing profession. Zilm and Warbineck (1994) and Kelly (1973) have both provided a detailed account of the emergence, rise, and structure of two of the most prominent schools of nursing in BC during the first half of the 20th century. This biography of Mary Richmond provides further insight and adds to the current BC nursing history by providing a personal perspective on nurses training in these schools and of the transitioning of nursing education post Second World War. This study reveals Richmond's intellect, perseverance and the dedication she embodied in improving nursing education and the nursing profession in BC.

A few areas or topics for future research that would contribute to the current historical nursing research could include further examination of why Canadian nurses looking to advance their education and leadership roles travelled to the United States to pursue their education goals. Focusing on where they went and what societal, economic or educational events influenced this movement would add to current research. For my thesis work I would have found it helpful to have scholarly information on the history of the School of Nursing at the University of Victoria. I believe this would add to the current research on schools of nursing in BC. Finally future biographies of nursing leaders would be a great addition to current research and there is no lack of rich and interesting subjects to choose from.

Lessons Learned

I have had gained several insights from undertaking this historical research. First off, it is important to ensure, as Grypma (2008) noted, prior to undertaking biographical research that there is enough primary sources to alleviate frustrations and ensure that the study's credibility will not be undermined. I had a significant amount of primary sourced material from BC History of Nursing archives but I did struggle at times to locate secondary sources in order to substantiate what the primary sources revealed. I found that some sections of the paper have had less support from the literature than other areas because of this reason. Secondly, this research has illuminated for me many significant influences that transformed nursing education during what seems to me a time in nursing that although appears exciting due to the many societal changes occurring must have been difficult to navigate to bring nursing and nursing education to where it is today. Finally I was initially attracted to investigating and researching Mary Richmond's life and career because of a sense of kinship in our shared interest in the development of nursing education and the encouragement of nurses to engage in lifelong learning. I also discovered however many other significant nursing leaders who were influential in the transformation of nursing during this time period. This discovery has increased my sense of pride in nurses, the nursing profession and my role within it.

My scholarly interest in Mary Richmond as a person has not only focused on her as an individual but also as a focal point within nursing history. There are a variety of interpretations a single life may stimulate therefore my interpretation of the life and career of Mary Richmond however unique, is open to re-interpretation. Through this project I have contributed to nursing scholarship by illuminating the life of nursing leader Mary Richmond, and acknowledging her

contributions to the profession while examining the relationships and influences of technology, demographics, resources and societal change on nursing and nursing education.

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Appendix A



Mary Richmond

Photograph from the Vancouver General Hospital Public Relations Department DO489. Courtesy of the British Columbia History of Nursing Society archives, circa 1966-1973

Appendix B

Timeline

