Saints and Sanitarians: The Role of Women's Voluntary Agencies in the Development of Winnipeg's Public Health System, 1882-1945

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Submitted to the Faculty of Graduate Studies in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

Department of History
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Saints and Sanitarians: The Role of Women's Voluntary Agencies in the Development of Winnipeg's Public Health System, 1882-1945

BY

Marion Lynne Clark McKay

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

Doctor of Philosophy

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Abstract

This thesis argues that gender shaped the roles available to the men and women who created Winnipeg's public health system between 1882 and the 1940s. Before the First World War, Winnipeg's male-dominated health department focussed almost exclusively on sanitation and regulation. At the same time, female social reformers founded two voluntary visiting nursing organizations and pioneered school health and maternal/child health programs. Gendered ideas about appropriate roles for men and women in the public sphere established the boundaries between these two approaches to public health. Because gender is an unstable construct, this division of labour changed over time. As female-led organizations became increasingly dependent on grants from organized charity and government, their managerial practices came under the scrutiny of male bureaucrats. These professional men destabilized the previously established boundaries between civic and voluntary public health programs. Voluntary organizations lost much of their autonomy and physicians exerted increased control over the practices of visiting nurses. Finally, many programs initiated by the visiting nursing associations were taken over by the civic health department.

Public health programs were also used to maintain social order and regulate individual behaviour. The programs pioneered by Winnipeg's visiting nursing associations were convenient vehicles for elite and middle class women to disseminate multiple messages to immigrant and working class women about the appropriate behaviours, attitudes, and beliefs expected of Canadian citizens.

Finally, this thesis demonstrates that women's contributions to Winnipeg's public

health system, although largely ignored in the standard histories, established a legacy and a pattern that shape the publicly funded system to this day. However, by 1945, lay women and professional nurses were virtually excluded from policy development within Winnipeg's public health system.

Acknowledgments

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Abbreviations

AM	Archives of Manitoba
CWA	City of Winnipeg Archives
The Mission	Margaret Scott Nursing Mission
NAA WGH/HSC	Nurses Alumni Association Winnipeg General Hospital/Health Sciences Centre Archives
VON	Victorian Order of Nurses for Canada

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As science advances, woman gradually acquires her true position in the scale of social life, the object of universal regard, the inimitable type of the artist's skill, the theme of the poet's happiest inspirations.

James E. Reeves
APHA President, 1885

Chapter 1

Introduction

Public health has been defined as the "combination of science, practical skills and beliefs . . . directed to the maintenance and improvement of the health of all the people."[1] Public health programs are organized and funded by society as a whole, they are delivered in the community, and they focus on health promotion and prevention of illness. However, no single definition of public health captures the range of philosophies that have shaped programs deployed to improve the health and well-being of all the people. Instead, public health must be conceptualized as an idea which is regularly re-invented to suit the spirit of a particular age.

From the orthodox histories of the discipline, a basic chronology of public health in Canada can be discerned. In the mid-to-late nineteenth century, public health meant sanitation. Thus, public health departments composed almost entirely of male administrators and employees focussed on the development of major public works designed to clean up city streets, provide safe water and food supplies, and safely dispose of sewage and garbage. The idea that public health officials should enter the homes of individual citizens was both socially repugnant and politically unacceptable. However, by the end of the nineteenth century, visiting nurses in the employ of elite female social reformers not only appeared in the community, but also crossed the thresholds which separated the city's public streets from its private spaces. Providing both health education and direct nursing care in the home to women and children, visiting nurses and their

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[1]Last, *Public Health and Human Ecology*, 8.

female employers demonstrated the contribution that direct contact with individuals and families might make in the campaign to eliminate the squalor, illness, and death so often encountered in the slums of the modern industrial city. Voluntary visiting nursing associations thus became a valued, but administratively and ideologically separate element in the wider public health campaign.

Early in the twentieth century, the limitations of sanitary and regulatory strategies became increasingly evident to public health officials. Therefore, they shifted their emphasis to incorporate educational strategies that reinforced and expanded the scope of their existing programs. Spurred in particular by a new interest in saving the lives of infants and young children, health departments began to employ small numbers of public health nurses to carry the "gospel of health" into the homes of the city's most vulnerable citizens, including recently arrived immigrants and the poor. By the second decade of the twentieth century, most large Canadian cities boasted health departments which deployed both regulatory and educational strategies. During this era, provincial public health departments also began to respond in a more organized fashion to the health issues faced by the country's large rural population.

In the interwar years, civic health departments underwent rapid expansion. By the end of the Second World War, health promotion and prevention programs offered by health departments had increased to include mental health programs, venereal disease control, pre-school health programs, prevention of chronic illnesses, and prenatal education. The development of public health programs in rural areas also continued, although these efforts were sporadic, fraught with difficulty, and often short-lived.

Ultimately, the increased costs associated with the development of more comprehensive public health programs forced a fundamental renegotiation of federal/provincial jurisdictions related to the provision of health and welfare programs in Canada and fostered the fuller development of the Canadian welfare state.

This received chronology captures shifts in the nature and delivery of public health programs, and traces changes in the political response to the health needs of Canadians. However, it fails to explore the extent to which the development of the public health programs extant today were a product of socially constructed assumptions about the appropriate roles that women and men might assume in the public sphere. The complexity of integrating a more deliberate analysis of gender's role in the development of public health programs in Canada and elsewhere precludes, at least initially, a regional or national focus.

"Saints and Sanitarians" is therefore a local study that analyses the contribution that both voluntary and civic organizations made to the development of Winnipeg's public health system. Its title reflects this reality. Voluntary programs were inspired by the example of Margaret Scott, who was eulogized by Archbishop Samuel Matheson in 1931 as "Saint Margaret of Winnipeg."[2] Sanitarians were more closely associated with the health department's early efforts to protect human health by focussing on the improvement of the city's sanitary conditions. As this thesis reveals, the saints were not always saintly; nor were the sanitarians oblivious to the need to move beyond regulation in order to improve the public's health. It traces the relatively contemporaneous

[2]MacVicar, *Margaret Scott*, 11.

establishment of a male-dominated civic public health department and two female-dominated voluntary visiting nursing agencies in Canada's most rapidly growing and cosmopolitan urban centre, and describes the gendered manner in which their respective mandates were conceived and implemented. It also explores the extent to which organized medicine's professional agenda influenced the development of public health programs both within the health department and the visiting nursing associations. Finally, it analyses the social and political forces which shifted the boundaries between these separate responses to Winnipeg's public health needs. The last chapter describes the consolidation of the majority of the public health programs pioneered by female social reformers into the civic health department. By the end of the Second World War, the emergence of scientific medicine and the consolidation of masculine control over publicly funded public health programs ushered in an era when women in Winnipeg were virtually excluded from participation in the policy development process which reshaped the public health programs they had founded less than half a century earlier.

This is not a comprehensive history of public health in Winnipeg. Instead, this thesis uses a case study approach to illustrate particular crises and turning points within the community as a whole, and within specific agencies mandated to maintain and promote the health of its citizens. In so doing, it reveals the gendered dimensions of Winnipeg's public health system and explores the transformation of the division of labour between male bureaucrats, on the one hand, and female philanthropists and health care workers, on the other, as the city's public health system professionalized and became fully integrated into the Canadian welfare state.

Rationale for the Study

The development of public health systems in Canada, the United States and Britain is marked by both differences and similarities. The unique relationship between civic, regional, and national governments in each of these countries shaped the political processes required to establish comprehensive public health programs that met the basic needs of its citizens regardless of where they lived. Thus, for example, Britain wrestled with the challenge of creating mechanisms for local authorities to develop public health infrastructures within a highly centralized system of government while Canada and the United States endeavoured to create equitable public health services nation-wide within a political system that placed responsibility for health care at the state or provincial level. The chronology of public health's development in each of the respective countries also varies. By the time that the United States and Canada had embarked on their public health programs during the last quarter of the 19th century, Britain already had five decades of experience with the provision of publicly funded public health programs.[3] Despite these differences, the development of public health in these three countries is also remarkably similar. Public health programs were initially established by local authorities in the countries' large urban centres. As well, the public health systems in all three countries were successively influenced by ideas and methods related to sanitation, bacteriology, and

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[3]For a more comprehensive discussion of these issues, see Porter, *The History of Public Health*, on particular, the chapters on the development of public health in Canada, the United States, and Britain: Cassell, "Public Health In Canada," 276-312; Fee, "Public Health and the Modern State," 224-275; Hamlin, "State Medicine in Great Britain," 132-164.

health education.[4] These similarities will be the focus of the analysis of both the current literature on public health included in this chapter and the programs included as case studies in the rest of the thesis.

It may be inferred, based on the many monographs, chapters and articles extant, that there is little left to be said about the history of public health in Canada and elsewhere. However, this body of literature must be regarded, not as the last word on the subject, but as the foundation upon which further work in this area is made possible. New studies, particularly those guided by more critical approaches to the subject, have the potential to promote a deeper understanding of the many social and political forces which have shaped the discipline of public health since the mid-nineteenth century.

The oldest form of public health histories are general works which take a very broad and uncritical approach to the subject. Monographs such as those describing the history of public health in the Western World from ancient times to the present, or those that describe the development of particular national or regional public health systems tend to portray the development of public health as a chronicle of progress (except, perhaps, for the Dark Ages) inspired by certain leading citizens' benevolent regard for the health and well-being of all people.[5] Although valuable records of the chronology of public

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[4]Fee, "Public Health and the Modern State," 244-246.

[5]For the most famous example of this approach to the history of public health, see: Rosen, *A History of Public Health*, which literally does span four centuries of public health in the Western world. Other world histories include Porter, *The History of Public Health*, an edited history of the development of public health systems in no less than twelve countries. Many medical and nursing textbooks on the subject of public health, and monographs on the history of medicine present a similar but much briefer overview of the historical development of public health in the Western world. Like the more

health's development, the sheer scope of such works precludes the detailed analysis that could reveal public health's many failures, biases, and hidden social agendas. In addition, these surveys focus almost entirely on the leadership role that scientific medicine played in public health's development, and only rarely mention the contributions of other professions, such as nursing and engineering. The virtual exclusion of public health nurses, who have outnumbered their medical counterparts since the early twentieth century, is a particularly striking oversight. These works also contain a limited analysis of the ordinary citizen's response to public health interventions, and of the contributions that voluntary and charitable agencies made to the practice of public health. They are also relatively silent on the issue of whether or not public health interventions have enhanced the well-being of all the people. The full range of consequences, both positive and negative, that public health programs had on the autonomy and dignity of those who were the objects of these interventions is rarely examined.

Health care professionals, including retired Canadian physicians and nurses, have

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extended works, these works are primarily descriptive and uncritical chronologies of the discipline's achievements. See, for example: Bynum, *Science and the Practice of Medicine*, 55-91; Clark, *Community Health Nursing*, 15-34; Last, *Public Health and Human Ecology*, 1-4. Examples of monographs with a national focus include: Bulloch and Rosen, *Preventive Medicine in the United States;* Canadian Public Health Association, *The Development of Public Health in Canada*; Duffy, *The Sanitarians*; Heagerty, *Four Centuries of Medical History in Canada*. Local histories of this genre can be found in publications such as: Andrews, "The Best Advertisement a City Can Have;" Carr and Beamish, *Manitoba Medicine*, 60-69; Duffy, *A History of Public Health in New York City*, vol. 1 and 2; Health New Brunswick, *Health Care in New Brunswick, 3-4, 7-8, 10-11, 13-14*; MacDougall, *Activists & Advocates*; Mitchell, *Medicine in Manitoba*, 69-75. Biographies of important leaders in the field of public health also adopt this approach. See, for example: Cassedy, *Charles V. Chapin*.

also written histories of public health, often in the form of biography or autobiography.[6] Although these serve as valuable primary sources for historians, they also lack an analytic edge and often fail to reveal public health's darker side. In addition, these works generally fail to integrate the wider political, social and economic context which shaped local developments and individual professional careers.

Local studies such as this analysis of the development of public health in Winnipeg have the potential to restore to the historic record the experiences of those who have been pushed to the margins by more traditional and general approaches to the subject. There is space in more focussed approaches to integrate the experiences of female social reformers and professional nurses so that their contribution to the development of public health can be better understood. Local newspapers can be used as a primary source. This facilitates the identification of local controversies, and the analysis of public resistance to the health department's policies and procedures. The perspectives of those who were the recipients of public health's many interventions also become more accessible. Case files are also a rich archival source for local studies, and recent innovations in the use of case files as primary sources for historians restores the voices and experiences of ordinary people to the history of public health.[7]

Much can be learned from alternative approaches to the history of public health.

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[6]See, for example: Baldwin, *She Answered Every Call*; Banfill, *Pioneer Nurse*; Colley, *While Rivers Flow*; Gibbon, *Lamp on the Snow*; Giovannini, *Outport Nurse*; Green, *Don't Have Your Baby in the Dory!*; Green, *Through the Years With Public Health Nursing*; Miller, *Mustard Plasters and Handcars*; Nevitt, *White Caps and Black Bands*; Wilson, *No Man Stands Alone*.

[7]Iacovetta and Mitchinson, eds., *On the Case*.

For example, in *Health, Civilization and the State*, Dorothy Porter argues that the development of public health is not merely "a narrative of sanitary progress." Taking a health of populations perspective, Porter argues that public health is inextricably linked to collective actions that have contributed to the formation of autonomous states.[8] This thesis extends Porter's analysis by examining the collective social and political processes that fostered the development of Winnipeg's civic health department within the context of the emerging Canadian welfare state.

Other more critical works on public health's general development are also available. Three Canadian historians have offered sharp criticisms of civic health departments' indifference to the plight of working class citizens.[9] Critical analyses of one aspect of public health's contribution to social reform and the provision of health care in the community are also available. Margaret Andrews, for example, in her analysis of the early years of the Vancouver Health Department, describes the increased medicalization of that organization. However, she stops short of suggesting that alternative approaches to the city's public health problems might have existed.[10] A more sustained critique of medicine's ultimate control over public health is provided by Barbara Rosenkrantz in her analysis of the development of public health in Massachusetts. The nineteenth century

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[8]Porter, *Health, Civilization and the State*, 7.

[9]Artibise, *Winnipeg*; Copp, *The Anatomy of Poverty*; Piva, *The Condition of the Working Class in Toronto*. The critiques of the public health departments in these three Canadian cities (Winnipeg, Montreal, and Toronto) are included within a much broader analysis of the socio-economic conditions faced by the working class rather than a sustained analysis of the respective city's public health systems.

[10]Andrews, "The Emergence of Bureaucracy."

belief in the essential harmony of nature and "man," she proposes, made social reform a legitimate strategy for medical health officers. In the post-bacteriological era, however, these physicians embraced a more circumscribed sphere of practice and rejected responsibility "for solutions to problems which originated from society's inequities."[11] Rosenkrantz also traces the consolidation of professional medicine's control over the state's public health agenda, identifying the establishment of schools of public health within schools of medicine as a development "which tended to narrow the area in which the public health official was competent to act and to make his judgements within this area decisive."[12]

More recently, searching critiques of public health in the pre-medical era have also emerged. Christopher Hamlin, in a recent monograph, persuasively argues that Chadwick's focus on sanitary reform in early nineteenth century Britain was a politically safe choice which narrowed the potential scope of public health and failed to challenge the fundamental structures of industrial capitalism. Sanitation, he asserts, was concerned with only certain aspects of mortality:

> Their [Chadwick and his followers'] sanitary movement was not a systematic campaign to eliminate excess mortality. Its concern was with *some aspects* of the health of *some* people: working-class men of working age. Women, infants, children, and the aged were largely ignored. . . . It tended, moreover, to represent those men in terms of their houses, streets, drains or towns.[13]

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[11]Rosenkrantz, *Public Health and the State*, 179.

[12]Rosenkrantz, *Public Health and the State*, 170.

[13]Hamlin, *Public Health and Social Justice*, 12

Hamlin's analysis has been criticized by some historians for collapsing the many other approaches to public health reform proposed in the nineteenth century and having Chadwick represent them all. In so doing, states Peter Mandler in his review article, Hamlin also ignores the possibility that another real alternative to Chadwick's sanitarian approach to public health was no public health at all.[14] However, Hamlin's timely reconsideration of Chadwick's career demonstrates that the history of public health remains a fertile field for historians interested in tracing the development of social institutions and delineating the role that ideologies such as gender played both in their creation and in the development of their policies and programs. By incorporating the contribution that lay female social reformers made to Winnipeg's public health system, this thesis moves beyond the more narrow and traditional accounts of the discipline's history and provides a fresh perspective on what has been sometimes described as an "exhausted" line of research.[15]

Hamlin is particularly critical of the frequency with which advances in scientific knowledge are used to explain or rationalize particular turning points in the history of public health. Science, he states, does not guide the responses of those in leadership positions within public health. It is "a resource parties appeal to (or make up as they go along) for use whenever authority is needed." Other historians have also noted that scientific and technical knowledge alone are not sufficient to protect the public's health. This theme is explored in two monographs examining early Canadian public health

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[14]Hardy, "Edwin Chadwick Revisited"; Mandler, "After the Welfare State."

[15]Mandler, "After the Welfare State," 382.

officials' efforts to contain epidemics. Bilson's analysis of their responses to outbreaks of cholera in nineteenth century Canada clearly illustrates the role that social assumptions about class played in distorting the implementation of quarantine regulations. Even the acceptance of contagion theory was made more difficult by pre-existing explanations of disease which focussed on poverty, intemperance, and filth.[16] Michael Bliss's *Plague: A Story of Smallpox in Montreal* integrates the impact of ethnicity, social class, and civic politics into an analysis of why public health officials' efforts to contain Montreal's 1885 smallpox epidemic failed and provides powerful insights into the reasons why scientific knowledge alone is not sufficient to contain potentially lethal organisms.[17]

Ultimately, what must be concluded from these and other innovative studies is that the decisions made by historic figures to shape the discipline of public health in a particular way cannot be accepted as the natural, the scientifically validated, or even the only option available to them. Nor can public health programs be uncritically accepted as equally beneficial to all citizens. This point is made by historians who have probed the impact of specific public health programs on the populations or communities within which they were deployed. Maternal/child health and school health programs have been the focus of historians interested in examining the ways in which middle-class social reformers attempted not only to decrease infant and childhood mortality, but also to

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[16]Bilson, *A Darkened House*. During the early cholera epidemics, steerage passengers on ships arriving from Europe and elsewhere were subject to inspection and quarantine. Cabin passengers, who were believed to be less likely to have the disease, were allowed to disembark without these measures having been implemented.

[17]Bliss, *Plague*.

impose the authority of scientific medicine and the state upon maternal child rearing practices, and to refashion the children of working class and immigrant families into model citizens.[18] These works have been heavily influenced by theoretical approaches that focus on the human impact of professional and state regulation, especially the regulation undertaken by government agencies mandated to protect the welfare of children, or to provide welfare services to single, abandoned, or widowed women.[19]

Within the growing body of literature examining the history of public health, only a few monographs focus on the role that gender played in shaping the discipline. As this thesis will argue, the ideological basis for public health's separate origins within male-dominated bureaucracies and female-led visiting nursing organizations rested upon social beliefs about perceived differences between the sexes. These differences were conceived to be hierarchical. Men had access to significantly more social and political power than women and, in addition, men exerted social, political, and interpersonal power over women. The ultimate expression of the binary categories of male and female was the creation of separate spheres. Women, because of their reproductive role (whether

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[18]See, for example: Arnup, "Educating Mothers;" Brosco, "Weight Charts and Well Child Care;" Comacchio, *Nations are Made of Babies*; Gleason, "Race, Class and Health;" Grant, *Raising Baby by the Book*; Harris, "Educational Reform;" Klaus, "*Every Child a Lion*; Markel, "For the Welfare of Children;" Marland and Gijswijt-Hofstra, "Introduction;" Meckel, *Save the Babies*; Peikoff and Brickey, "Creating Precious Children;" Stern, "Better Babies Contests at the Indiana State Fair;" Sutherland, "To Create a Strong and healthy Race;" Sutherland, *Children in English-Canadian Society*; Viner, Joseph, "Abraham Jacobi and the Origins of Scientific Pediatrics in America;" Wohl, *Endangered Lives*; Wolf, *Don't Kill Your Baby*.

[19]Christie, *Engendering the State*; Davin, *Growing Up Poor*; Gordon, *Heroes of their Own Lives*; Gordon, *Pitied But Not Entitled*; Holloran, *Boston's Wayward Children*; Little, *No Car, No Radio, No Liquor Permit*; Ross, *Love and Toil*.

actualized or not), were necessarily confined to the domestic sphere. Their purportedly greater capacity for nurturing and self-sacrifice gave them moral (but not legal) authority over men in the private sphere, but excluded them from social and political power in the public sphere. However, because the roles accorded to women were products of social processes and always defined in relation to those held by men, gender was an unstable construct. Thus, the power ascribed to both men and women and the shape of the social institutions through which this power was deployed shifted over time.[20] This thesis argues that the changes observed in Winnipeg's public health system during the period under study were not simply a product of political processes. Underlying the political process was an ideology that influenced the subjective identities of both male bureaucrats and female social reformers. Gender shaped the roles available to them, the power relationships between them, and the social institutions with which they interacted.

Analyses based on gender have produced helpful critiques of specific public health programs. For example, public health's campaign to reduce the spread of sexually transmitted diseases has been criticized by historians who assert that these efforts were part of a wider social effort to regulate the sexual behaviour of women. Britain's Contagious Diseases Acts have received particular attention as mechanisms which established the medico-legal surveillance of prostitutes and which placed the blame for transmission of these diseases squarely upon (primarily working class) women. Thus,

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[20]For a more in-depth discussion of gender and its relationship to power, social roles, and the development of social institutions, see: Poovey, *Uneven Developments*; Poovey, *Making a Social Body*; Riley, "Does Sex Have a History?"; Scott, *Gender and the Politics of History*.

considerable effort was put into the creation of moral campaigns which would discourage women from becoming prostitutes, and the creation of institutions to rescue women who had already engaged in unlicensed sexual behaviours.[21]

In addition to probing the extent to which public health has contributed to the social control/moral regulation of individual citizens and to the maintenance of the prevailing social order, recent histories also consider how the health care professions, particularly organized medicine, shaped the development of the welfare state through their greater access to political power and their control of biomedical knowledge. Although the subject of extensive analysis by historians of the professions and by feminist historians and sociologists, this theme has received little sustained attention in the history of public health.[22]

Public health nursing, for example, has been described as the most autonomous

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[21]For discussions about the use of the Communicable Diseases Acts to regulate the sexual activity of women, see, for example: Kent, *Sex and Suffrage*; Mahood, *The Magdalenes*; Mort, *Dangerous Sexualities*; Walkowitz, *Prostitution and Victorian Society*. Adam's analysis of the establishment of VD programs in Ontario provides a similar critique. See: Adams, "In Sickness and in Health." Other works on the subject of moral regulation, but which are not directly focussed on public health, can also provide insight into how public health departments can function as apparatuses of the state which regulate the behaviour of citizens. See, for example: Adams, *The Trouble with Normal*; Foucault, *Discipline and Punish*, Hunt, *Governing Morals*; Lévesque, "Deviants Anonymous;" Mahood, *Policing Gender*; McLaren and McLaren, *The Bedroom and the State*; Rose, *Governing the Soul*; Stoler, *Race and the Education of Desire*; Strange, *Toronto's Girl Problem*; Strange and Loo, *Making Good*.

[22]For examples of analyses of the rise of professional power, with a particular focus on medicine, see: Berlant, *Profession and Monopoly*; Gidney and Miller, *Professional Gentlemen*; Goldstein, "Foucault Among the Sociologists;; Kimball, *The "True Professional Ideal" in America*; Perkin, *The Rise of Professional Society*; Reaume, *Remembrances of Patients Past*; Walkowitz, *Working With Class;* Witz, *Professions and Patriarchy*.

practice available to graduate nurses.[23] While this may be true, the extent to which these nurses were subordinated to medical health officers and physicians in private practice is an important but under-explored theme in the history of public health nursing. A particularly interesting omission in the general literature on the history of public health is the lack of systematic analysis of the strategies used by physicians in general and medical health officers in particular to exert professional power over visiting and public health nurses. Traditional accounts tend to portray nursing's subordination to medicine within the public health system as part of the natural order of things. Biographies and autobiographies of public health nurses, and organizational histories written by former public health nurses also rarely go beyond suggesting that physicians exerted control over the practice of nurses working in the community.[24]

Other monographs explicitly identify the subordination of public health nurses to professional medicine as a problem which both frustrated the nurses and inhibited them as they sought to put their knowledge and skills to use.[25] In her analysis of the experience of provincial public health nurses hired to work in Ontario's rural child welfare project (1916-1930), Meryn Stuart provides insightful and compelling descriptions of the nurses'

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[23]McPherson, *Bedside Matters*, 59; Reverby, *Ordered to Care*, 110.

[24]See, for example, Green, *Through the Years with Public Health Nursing*.

[25]For excellent examples of public health nursing's subordination to both medical health officers and physicians in private practice, see: Buhler-Wilkerson, *False Dawn*; Stuart, 'Half a Loaf is Better than No Bread;' Stuart, "Ideology and Experience;" Stuart, *'Let Not the People Perish for Lack of Knowledge'*. Buhler-Wilkerson asserts that by the 1930s, professional autonomy had slipped from the grasp of visiting and public health nurses in the United States.

frustrations as they endeavoured, against considerable odds, to convince local authorities to establish permanent child welfare programs after their effectiveness had been proven by a short term provincially-funded demonstration project. Local physicians were often less than helpful, perceiving the nurses as a potential threat to their incomes. Although generally grateful for their interest and concern, local citizens were also sceptical and voiced a distinct preference for nurses who provided bedside nursing care rather than health education. The child welfare nurses quickly realized the futility (and perhaps even the cruelty) of focussing on preventive programs in a population that needed basic medical care and felt helpless in the face of the abject poverty they encountered in the course of their work.[26] Although valuable additions to the history of public health, this analysis of nursing's particular experience has not been fully integrated into the discipline's broader history. To answer the question of why public health nursing failed to achieve full professional autonomy, however, requires more than simply bridging the existing gap in the literature between histories of public health and histories of public health nursing. The increasing dominance of scientific medicine over public health programs and the practices of public health nurses must also be analysed through the lens of gender. Professional power, as Anne Witz argues, is a potent combination of patriarchy, which subordinates women in the domestic realm, and capitalism, which subordinates them in the public sphere.[27] In the case of medicine, professional power deployed through social and political institutions enabled physicians to both limit the

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[26]Stuart, *'Let Not the People Perish for Lack of Knowledge.'*

[27]Witz, *Professions and Patriarchy*, 11-38.

nursing profession's capacity to develop its own knowledge and practice, and to supervise their use of the knowledge produced by scientific medicine. This thesis analyses the process by which physicians in Winnipeg brought both visiting nurses and public health nurses under their direct control.

There is considerable confusion in the literature about whether or not public health nursing and visiting nursing are distinct branches of community nursing or merely interchangeable terms. In her groundbreaking analysis of twentieth-century Canadian nursing, Kathryn McPherson divides the profession into three sectors: hospital nursing, private duty nursing, and public health nursing.[28] Public health nurses, according to McPherson, were employed by private and public agencies to deliver a range of services in the community, including the provision of bedside nursing care in the home. McPherson bases her classification system on the nature of the nurses' employment. In other words, the employer determined the sector of the profession to which the individual nurse belonged. Hospitals created hospital nurses, paying patients in the private sphere created private duty nurses, and agencies in the public sphere, whether voluntary or governmental, created public health nurses.

Other historians have defined public health nursing and visiting nursing as different forms of community nursing and have used the nature of their work to distinguish between the two groups. In this approach, public health nurses were defined by their focus on health education and prevention of illness, while visiting nurses provided bedside nursing care. For example, Susan Riddell states that public health

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[28]McPherson, *Bedside Matters*, 47-63.

nurses, the employees of civic and provincial public health departments, emphasized health education, prevention of illness, and social reform rather than the bedside nursing services provided by visiting nurses such as those employed by the Victorian Order of Nurses.[29]

Although it is appropriate, at least in Canada, to distinguish between public health nurses and visiting nurses rather than use the terms interchangeably as McPherson does, it is not entirely accurate to divide the scope of their respective practices as Riddell has suggested. Descriptions of the practices of early American visiting nurses reveals that health education and prevention of illness were integral to their practices.[30] Indeed, visiting nursing organizations such as the Henry Street Mission in New York City were committed to a wide range of public health and social reform projects. Similar descriptions of the wide range of services offered by the Victorian Order of Nurses in Canadian cities confirm that the boundaries between public health and visiting nursing were fluid and were shaped by local opportunities and needs.[31]

Scholars also disagree about whether the public health nurse or the visiting nurse emerged first. Here, opinion seems to be divided along national lines. Canadian sources

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[29]Riddell, "Curing Society's Ills," 6-7.

[30]See, for example: Estabrooks, "Lavinia Lloyd Dock: The Henry Street Years."

[31]Buhler-Wilkerson, *False Dawn*; Buhler-Wilkerson, *No Place Like Home*; Fitzpatrick, *The National Organization for Public Health Nursing,* 5-8; Gibbon, *The Victorian Order of Nurses for Canada*; Penney, *A Century of Caring*.

state that public health nurses were preceded by visiting nurses.[32] American sources argue that public health nurses came first. Buhler-Wilkerson, in her analysis of early community nursing in the United States, states that the once unified practice of public health nursing divided as bedside nursing programs became separated from preventative programs. Ultimately, these two functions resided within separate agencies, either visiting nursing associations or public health agencies.[33] The disagreement between Canadian and American sources appears to centre around terminology. In both countries, early community nurses focussed primarily on bedside nursing care and integrated other functions such as health education when opportunities for these services arose.

There is also disagreement about when public health nursing emerged as a distinct practice in Canada. Riddell, for example, argues that public health nurses emerged in Canada after the First World War in response to a broad social reform movement which emphasized the "gospel of health."[34] Certainly, the difficult years following the war were marked by a renewed interest in the role that public health nurses could play in the

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[32]Emory, *Public Health Nursing in Canada*, 24-25; Riddell, "Curing Society's Ills," 6-7.

[33]Buhler-Wilkerson adopts terminology used by Lillian D. Wald, founder of the Henry Street Nurses Settlement in New York City. Wald coined the phrase "public health nurse" over one hundred years ago to describe a new role for nurses who visited the homes of the sick poor. American usage has consistently maintained Wald's definition. For example, the National Organization for Public Health Nursing represented primarily *visiting* [italics mine] nursing associations. Nurses employed by civic public health departments were more likely to affiliate with the American Public Health Association. Buhler-Wilkerson, *False Dawn*, 131-177, 287-288; Buhler-Wilkerson, *No Place Like Home*, 98.

[34]Riddell, "Curing Society's Ills,"6-7.

creation of a better society. Provincial governments, the Canadian Red Cross, and the Rockefeller Foundation provided funding which supported an enlarged mandate for existing health departments, the extension of these programs into rural Canada, and the establishment of university based programs to prepare diploma educated nurses for public health work.[35] The number of public health nurses in Canada increased dramatically during the 1920s.[36] However, these were not, as Riddell would have it, the first public health nurses. In 1906, the Ottawa health department employed a public health nurse to visit the homes of individuals suffering from tuberculosis.[37] By 1914, civic health departments in Toronto and Winnipeg employed public health nurses to deliver a range of child hygiene, school health, and communicable disease control programs.[38]

It is evident, therefore, that the chronology and the processes by which Canadian visiting nursing and public health nursing emerged as distinct practices were inherently more disorderly, ill-defined, and idiosyncratic than existing analyses have portrayed. A local study such as this one provides insights into how local opportunities and constraints shaped the mandates of publicly funded and voluntary community health care agencies and the practices of the nurses that they employed.

Female social reformers' contributions to the practice of public health are also not

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[35]Hutchinson, *Champions of Charity*; Stuart, 'Let Not the People Perish for Lack of Knowledge;' Riddell, "Curing Society's Ills."

[36]Mansell, *Forging the Future*, 78-79; Stuart, "War and Peace," 172, 185.

[37]Meiklejohn, "Anti-Tuberculosis Work in Canada," 583.

[38]CWA, Health Department *Annual Report* (1914): 15; MacDougall, *Activists & Advocates*; Royce, *Eunice Dyck: Health Care Pioneer*.

documented in the existing body of literature. Historians of specific publicly funded health departments have tended to confine their analyses to developments within these organizations.[39] When the contributions of voluntary agencies are discussed, it is usually under the rubric of progress: the story of how small voluntary organizations were eventually closed and their work integrated into the operations of publicly funded health departments. An analysis of how publicly funded health departments and charitable voluntary agencies interacted, cooperated, inspired, competed with, and interfered with each other remains to be written.

Historians working in the fields of gender history and the history of moral regulation have produced extensive analyses of the mixed legacy of elite and middle class female social reformers in Canada, the United States, and Great Britain.[40] There is little doubt that the establishment of charitable agencies provided women with socially sanctioned opportunities to work in the public sphere and to enjoy some degree of autonomy and power, at least within their own organization and over the staff and clients associated with it. Some monographs seek to correct the historic record through a fuller analysis of the role that women played in projects of social reform, particularly within the

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[39]See, for example, Duffy, *A History of Public Health in New York City, 1866-1968*; Green, *Through the Years with Public Health Nursing*; Leavitt, *The Healthiest City*; MacDougall, *Activists and Advocates*; Rosenkrantz, *Public Health and the State*; Riddell, *Curing Society's Ills*.

[40]See, for example: Burke, *Seeking the Highest Good*; Crocker, *Social Work and Social Order*; Gordon, *Pitied But Not Entitled*; Kunzel, *Fallen Women, Problem Girls*; Little, *No Car, No Radio, No Liquor Permit*; Ross, *Love and Toil*; Valverde, *The Age of Sunlight, Soap and Water*.

social gospel movement.[41] Others, often taking a post-colonial theoretical stance, examine the role that these women played in furthering the interests of empire and nation by exerting cultural and religious control over immigrants in their own countries, and over colonial subjects in the mission fields abroad.[42] While their efforts to rescue abandoned and abused children, to provide nursing care to the sick, to shelter unwed mothers, and to rescue "fallen women" are generally acknowledged as important contributions to the development of health and welfare services during an era when these programs were not provided by the state, female social reformers are also often characterized as paternalistic, conservative, and judgmental. Within social service agencies such as homes for unwed mothers, the increasingly old-fashioned evangelical approach to social reform espoused by female social reformers led to open conflicts with professional social workers, and a "protracted transfer of power" from lay women to professional women ensued.[43] This thesis examines the relationship between lay female social reformers, organized medicine, and the civic health department in Winnipeg. It traces the protracted transfer of power over public health programs which served many of the needs of women and children from lay women to male physicians and bureaucrats.

The erosion of female power and autonomy which occurred during the rise of the

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[41]See, for example: Edwards and Gifford, *Gender and the Social Gospel.*

[42]See, for example: Huber and Lutkehaus, "Introduction: Gendered Missions at Home and Abroad;" Robert, *American Women in Mission*, particularly Chapter 4 "Woman's Work for Woman;" Rutherdale, *Women and the White Man's God*; Thorne, "Missionary-Imperial Feminism."

[43]Kunzel, *Fallen Women, Problem Girls*, 3.

welfare state and the transfer of voluntary public health programs to publicly funded health departments has not been fully examined. However, the oppressive surveillance of women by both voluntary and state-sponsored programs has been eloquently described in the existing literature.[44] For these women, the transfer of health and welfare programs from female social reformers to professionals and bureaucrats was not a liberation. It was simply an organizational change whereby the oppression exerted by female social reformers was replaced by similar, and possibly more systematic surveillance by bureaucrats. In the same vein, female professionals may have wrested power from the hands of lay women, but this victory becomes less significant when weighed against the reality that within publicly funded health and welfare programs, male bureaucrats and physicians had already gained the upper hand. In government bureaucracies, professional social workers were subordinated to psychiatrists, and professional nurses worked under the control of medical health officers.[45]

Little attention has been paid to the erosion of meaningful female participation in public policy development during the era when the welfare state began to incorporate the programs pioneered by female-led charitable organizations into their operations. Although their replacement by state funded organizations might be viewed as a

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[44]See, for example: Gordon, *Heroes of their Own Lives*; Gordon, *Pitied But Not Entitled*; Kent, *Sex and Suffrage*; Kunzel, *Problem Women, Fallen Girls*; Lévesque, "Deviants Anonymous;" Mahood, *Policing Gender*; Mahood, *The Magdalenes*; McLaren and McLaren, *The Bedroom and the State*; Mort, *Dangerous Sexualities*; Strange, *Toronto's Girl Problem*; Walkowitz, *Prostitution and Victorian Society*.

[45]For an analysis of the experience of female social workers in publicly funded systems, see: Walkowitz, *Working With Class*. For works describing public health and visiting nurses' subordination to medicine, see footnote 19.

progressive step, one might argue instead that it was yet another example of the suppression of female autonomy by the welfare state. One recent doctoral dissertation which examined the contribution made by female reformers to the development of Los Angeles' health department concluded that while the city did undertake responsibility for many of the programs initiated or proposed by female reformers, women were essentially excluded from further input into health policy development. Further, the city's vision of public health was considerably more narrow than that espoused by female reformers, and its interventions depended more upon coercing clients than on gaining their cooperation.[46] Within the Canadian context, much can be learned by a careful examination of how professional women were placed within expanded public health departments in the first half of the twentieth century, and what roles remained available to them and to lay female reformers during and immediately after the post-war planning era of 1941-1945.

The Basic Organization of the Thesis

This thesis traces the shifting definitions of public health in Winnipeg between 1882 and 1946, analyses the social and political forces which underlay them, and describes how these shifts transformed the delivery of public health programs in the city. It will argue that, although women played a major role in the creation of public health programs in Winnipeg, they did not possess social and political power equivalent to that available to men. Women's work in the public realm, therefore, was more likely to focus on issues perceived as having limited political and economic implications for the community as a whole. For example, the seemingly straightforward needs of women,

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[46]Koslow, "Eden's Underbelly."

children, and the poor provided fertile ground for the work of charitable agencies operated by lay women in the early years of the twentieth century. In contrast, the apparently more complex nature of efforts to improve the sanitary condition of the city, and to contain communicable diseases such as tuberculosis and typhoid fever required financial, organizational, legal, and political resources beyond women's reach. Responses to these threats to public health could only be mounted by civic and provincial bureaucracies, which were almost exclusively male dominated. As the emerging welfare state redefined social and political priorities and refocused attention on the contribution that women, children, and immigrants made to the process of nation building, male politicians turned their attention to the public health programs organized and financed by women, and redefined these as legitimate responsibilities of the state.

Chapter 2 describes the development of Winnipeg's public health system in the late nineteenth century and sets these developments within the context of wider efforts in Canada, the United States, and Britain to respond to the impact of unplanned and unregulated urban growth. Building on Poovey's argument that the ideology of gender actually provided women with a legitimate space within the public realm, this chapter also delineates the gendered division of labour between male and female social reformers in Canada.[47] Male bureaucrats and medical health officers busied themselves improving the sanitary conditions of the city and establishing early public health regulations to create safe food and water supplies. Women, on the other hand, sought to relieve the suffering of working class and immigrant women and children. Conceptualizing their work as a

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[47]Poovey, *Making a Social Body*, 27, 43.

natural extension of their domestic responsibilities, they established visiting nursing organizations to provide direct nursing care and health education in the home. The founding of the Victorian Order of Nurses for Canada is briefly discussed as an example of women's responses to the unmet health needs of Canadian women and children. In Winnipeg, the tentative beginnings of a visiting nursing organization can be attributed to one individual. Inspired by Margaret Scott, Winnipeg's revered female missionary, male-dominated organizations and individual male philanthropists provided the initial funding to employ a visiting nurse to assist her in her work. However, the lack of continuous funding from these sources betrays the limited priority which male social reformers placed on this program. The chapter concludes that prevailing social beliefs about the role that government might play in providing health care programs to citizens shaped the vision of men and women alike, motivating men to focus on regulation and creating opportunities for women to offer woman- to-woman public health services in the public sphere.

Joan Wallach Scott argues that binary definitions of male and female are set in opposition to and shaped within the context of the other.[48] Therefore, in order to understand women's experience in the development of public health programs, it is necessary to set the analysis within the context of men's experience in the same endeavour. Chapter 3 sets up this binary relationship by exploring the extent to which civic public health programs of the late nineteenth and early twentieth century were dominated by men who focussed on sanitary and regulatory strategies. Winnipeg's efforts

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[48]Scott, *Gender and the Politics of History*, 7.

to create a safe milk supply for its citizens is used as a case study to analyse the extent to which this sanitarian strategy was both implemented and resisted by men. It explores the attempts of physicians and veterinarians to promote their own professional interests and to consolidate their grasp on important positions within the city's health department by influencing the public debate about dairy regulations and tuberculin testing. While women played a very limited role in the public debate, they were actively encouraged to use their power as consumers to create the additional political pressure that would enable one or another of the male-dominated interest groups to carry the day. The chapter concludes that the positions of both men and women on this issue were determined by social and economic realities rather than by gender. It further concludes that the health department's focus on the eradication of tuberculosis from the milk supply needlessly exposed countless Winnipegers to other milk-borne diseases while having a limited impact on the epidemiology of tuberculosis in the community.

Chapter 4 examines women's moral influence in the public sphere between 1900 and 1940. It describes the work of the Margaret Scott Nursing Mission and examines the social forces that made the organization and management of visiting nursing programs a legitimate activity for Winnipeg's female social reformers. Although inspired and sustained by the increasingly old-fashioned discourse of philanthropy, the Mission's strategic alliances with the social gospel movement and maternal feminism enabled it to maintain the support of prominent citizens and the city's public health officials well into the 1930s. It further examines how these women made a meaningful and lasting contribution to the growth and development of Winnipeg's public health system by

pioneering several programs which were ultimately transferred to the city health department. The chapter concludes that the Scott Mission made a significant, but as yet unacknowledged contribution to both public health and to the development of the Canadian welfare state.

In 1905, the Winnipeg Branch of the Victorian Order of Nurses for Canada also established a visiting nurse service in the city. Chapter 5 examines how the VON and the Scott Mission differentiated themselves by dividing their work between charitable nursing, provided by the Mission, and non-charitable nursing, which was provided by the VON. The VON's more professional approach to its work, which was characterized by the early establishment of a Medical Advisory Committee, higher educational standards for its nurses, and its active participation in the city's Federated Budge scheme is discussed. Despite its apparently more progressive approach to the management of a visiting nursing agency, the VON could not escape the patriarchal control of male politicians, physicians, and businessmen. Its increased dependence on external funding created a succession of financial crises, and it experienced increasingly more stringent masculine surveillance of its administrative decisions, its nurses, and its clients. As a result, the VON lost both fiscal and professional autonomy.

This chapter argues that the constant demands that the VON realign its fiscal and managerial practices to satisfy the demands of male professionals and bureaucrats reveals the instability of the gendered assumptions upon which Winnipeg's early public health system was founded. The evolution of the charity organization movement and the emergence of the welfare state, both of which were dominated by males, destabilized

women's authority over the social institutions they had founded. Similarly, the employment of visiting nurses to provide direct nursing care and health education in the home was perceived by Winnipeg physicians as a threat to both their financial stability and their desire to consolidate medicine's authority over health care. Over time, childbirth and the care of children became medicalized, and health care practises previously perceived as the appropriate purview of women were brought within the scope of medical practice. Exercising the professional power that both gender and patriarchy made available to them, Winnipeg physicians created regulatory strategies which subordinated visiting nurses to medicine's professional project and ensured that nurses worked under their direct supervision.

Canadian and American historians have argued that one of the underlying purposes of public health programs was the inculcation of middle class and British cultural standards in the thinking and behaviour of the poor and of non-English speaking immigrants. Chapter 6 builds on previous work to consider whether and to what extent the visiting nursing programs organized by elite women were projects of moral regulation intended to reshape Winnipeg's immigrant women and children into "model Canadian" citizens.

Child health programs were one of the first public health programs to emerge in the late nineteenth and early twentieth centuries. They were intended to reduce the appalling infant mortality rates experienced in most major industrial cities of the time. In contrast to other public health programs which tended to be divided along gendered lines, child health programs were often joint ventures between male public health officials,

physicians in private practice, female social reformers, and visiting nurses. Chapter 7 examines the development of child health programs in Winnipeg. Initially, these were cooperative ventures between male civic authorities and female social reformers. The Margaret Scott Nursing Mission offered a child health program in cooperation with the city's Health Department. Similarly, the VON offered child health programs in Winnipeg's suburbs in cooperation with provincial Department of Health. As pediatrics emerged as a medical speciality in the first two decades of the twentieth century, the ideal of scientific motherhood replaced earlier ideologies which gave women authority over child rearing practices. Scientific motherhood advanced medicine's professional project, and made both mothers and visiting nurses dependent on physicians for advice and guidance. During the same era, infants were re-conceptualized from helpless family members requiring mother love to future citizens requiring the support of the state. Thus, both the state and the medical profession reshaped the unstable boundaries between men's and women's work, and diminished the autonomy women had previously exercised over the nurturing of children. This chapter examines the process by which child health programs were ultimately removed from female-led voluntary agencies and incorporated within the male-dominated departments of health. It also assesses the impact that cooperation between visiting nursing associations, professional medicine, and the civic health department had on the autonomy of both female social reformers and professional nurses.

By the end of the Second World War, a major shift had occurred in Canadian attitudes about the government's responsibility to provide health care to its citizens.

Chapter 8 examines the impact of the Canadian welfare state's emergence on Winnipeg's public health system. During the final years of the Second World War, both the provincial and city governments reorganized their public health programs along more masculine and professional lines. This chapter argues that as public health services provided by voluntary charitable organizations were drawn into local and provincial departments of health, the autonomy of female social reformers and professional nurses was subordinated to the fiscal and bureaucratic control of male bureaucrats, politicians, and physicians.

Ultimately, this thesis seeks to challenge a wide consensus within the history of public health that the emergence of a publicly funded system was a progressive and unproblematic development. Other historians have already described the continued marginalization of dependent women, children, immigrants, and racialized others as social reform programs moved from voluntary to governmental control. This thesis argues that, in the welfare state, professional nurses and female social reformers also lost their authority and autonomy. In the late nineteenth century, the domestic ideal had created a space which enabled both female social reformers and professional nurses to participate in the development of Winnipeg's public health system. The consolidation of medicine's professional project and the enlarged male-dominated bureaucracy of the welfare state, however, refashioned the boundaries between women's work and men's work in the public sphere. Ironically, in an era where women had finally attained full citizenship and the right to participate in the democratic process, meaningful involvement in policy development within the public health system had slipped from their grasp. In the process, female social reformers witnessed the disruption of a more personal and immediate

response to public health issues that they had developed during a half century of involvement in the public sphere. In the new state, their participation in policy development would take place on terms defined by "science" and by political debate, both of which were overwhelmingly shaped by men.

Chapter 2

The Separate Worlds of Public Health: Male Bureaucrats and Female Philanthropists in the Late Nineteenth and Early Twentieth Centuries

When Manitoba became Canada's fifth province in 1870, its capital city, Winnipeg, was a frontier settlement of approximately 100 souls who eked out uncertain livelihoods as fur traders and subsistence farmers along the banks of the Assiniboine and Red Rivers. In 1874, one year after its ambitious citizens orchestrated its incorporation as a city, Winnipeg still occupied only 3.1 square miles of land and boasted a population of 1,869. However, through a combination of luck and political manoeuvring, Winnipeg's destiny became entwined with the federal government's program of Western agricultural expansion. Winnipeg was a major destination for settlers travelling from ports and communities in eastern Canada, and the primary distribution centre for the supplies required by farmers and businessmen living further west. Agricultural commodities, primarily wheat, passed through Winnipeg en route to eastern Canada and markets abroad. The city grew rapidly in response to its central role in the making of the nation. By 1914, Winnipeg had grown to 23.6 square miles in size and its population had increased to 202,255. The sleepy settlement on the outpost of the Empire became, in the space of a generation, the gateway to the West and Canada's third largest city.[1]

Winnipeg's explosive population growth created public health problems that matched in scope, if not in scale, those experienced by other major European and North

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[1]For a more extensive discussion of Winnipeg's growth during this era, see: Artibise, "Boosterism and the Development of Prairie Cities," 515-543; Friesen, *The Canadian Prairies*; Morton, *Manitoba: A History*; Gibbins, *Prairie Politics & Society*; Norrie "The National Policy and the Rate of Prairie Settlement," 243-263.

American cities. Local authorities were ultimately forced to respond to the appalling urban mortality rates by establishing health departments within civic governments.

The purpose of this chapter is to describe the first steps in the establishment of Winnipeg's public health system, and to set these developments in the context of other urban centres that also struggled with the challenges of responding to the squalor and death that accompanied unplanned and largely unregulated urban growth. This chapter argues that the ideology of gender shaped public health in Winnipeg, resulting in its separate origins within male-dominated bureaucracies and female-led visiting nursing organizations. Social beliefs about masculinity resulted in the development of a civic health department that emphasised sanitary infrastructure development and the creation and enforcement of health regulations. Health departments of the time did not provide direct health care services such as bedside nursing care, because the provision of these services was not considered to be appropriate work for men. Paradoxically, the limitations placed on men's work in the public sphere created an opportunity for women to respond in their own way to unmet needs in the community. Women extended their moral authority and nurturing skills beyond their own individual domestic spheres to include the homes of "unfortunate strangers." Thus, in Winnipeg, women founded visiting nursing organizations to alleviate the suffering of poor women and children. This chapter delineates the early shape of this division of labour between the male bureaucrats and female social reformers who responded to Winnipeg's public health crisis in the late nineteenth century, and who organized civic and voluntary efforts to preserve and protect the public's health.

The Development of Civic Health Departments in Canada, 1867 - 1920

The idea that health care was a right of citizenship rather than a privilege based upon social rank and income developed slowly during Canada's first century. The British North America Act (1867) made only limited provisions for a Canadian health care system. The Act specified that the federal government was responsible for quarantine and for the establishment of Marine Hospitals. All other responsibilities for the provision of health care, including public health services, devolved to the provinces. Provincial responsibilities were not specified in the Act, and in the early years after 1867, the provinces did not make much effort to undertake them. Such organized health care as did exist was provided at the local (municipal) level through public welfare or, more frequently, charitable organizations. Many provinces passed enabling legislation in the late nineteenth century which allowed for the establishment of local and provincial departments of health. However, even at the local level, there was considerable reluctance to provide public health services on a permanent basis. Most early health departments were organized in response to a specific local emergency such as a cholera or smallpox outbreak. When the emergency was over, they were dissolved.[2] Similarly, Medical Officers of Health were appointed on a part-time basis. Toronto, for example, only appointed its first permanent medical health officer in 1883.[3]

These arrangements were consistent with the social attitudes of the times. In an era when individuals were expected to provide for their own health care and governments

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[2]Bilson, *A Darkened House*; Cassel, "Public Health in Canada," 278.

[3]Cassel, "Public Health in Canada," 288; MacDougall, *Activists & Advocates*, 10.

were not permitted to intrude into the personal lives of individual citizens, health departments threatened to blur the boundaries between the public and private spheres. The state neither expected nor was expected to undertake any responsibility for the health care of individuals and families. Those who could afford to pay for their own health care did so. Those who did not have the financial means to make these arrangements either went without care or, if sufficiently desperate or destitute, turned to local governments or charitable organizations for assistance.

Civic health departments were established to respond to the rising mortality rates created by the unsanitary living conditions, overcrowding, and overwhelming poverty that accompanied the movement of countless rural and immigrant families to urban centres. Infant and maternal mortality rates climbed steadily. Outbreaks of smallpox, cholera, typhoid fever, and influenza killed thousands of urban dwellers. Tuberculosis emerged as the leading cause of death for those who had survived early infancy.[4]

Although the chronology varies somewhat, early health departments, both in Britain and North America, initially focussed on the creation of large public works such as water and sewage systems, street construction, and organized street scavenging to remove refuse from the urban environment.[5] Underlying these efforts was the belief that the miasma or "bad air" emanating from foul environments caused human disease. Thus,

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[4]For descriptions of the living conditions and patterns of disease in large British, American, and Canadian cities of the late nineteenth century, see: Bliss, *Plague*; Eyler, *Victorian Social Medicine*; Humphreys, "Tuberculosis," 136-141; Leavitt, *The Healthiest City*; MacDougall, *Activists and Advocates*; Wohl, *Endangered Lives*.

[5]See, for example: Fee, "Public Health and the State," 234; Hamlin, "State Medicine in Great Britain," 143-145.

it was reasoned, the removal of raw sewage, garbage, and other sources of foul odours should decrease contagious diseases and human mortality. Sanitary reforms, which required the outlay of unprecedented levels of public funding, were planned and implemented by male bureaucrats and public health officials. Only men had direct access to the political power necessary to enact enabling legislation and to raise the necessary funds through taxation.

The sanitarian and bacteriological principles that guided the development of early health departments were drawn from the masculine world of science and technology. Both organized medicine and engineering made significant contributions to the development of early civic health departments, and it was from the ranks of these professions that the majority of early public health officials were drawn. Medicine and engineering were also bastions of male privilege. Both were virtually closed to women through a combination of structural and ideological barriers which effectively barred them from qualifying for membership in these professions.[6]

The new science of bacteriology emerged between 1877 and 1883 after Pasteur and Koch's discoveries of the causative organisms for tuberculosis and cholera. Bacteriology was also a masculine enterprise, and women had limited access to the necessary scientific training necessary to work in this field. Bacteriology reshaped the focus of public health programs from an exclusive emphasis on sanitary programs to include new interventions which sought to interrupt the transmission of disease causing

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[6]Gidney and Millar, *Professional Gentlemen*; Kimball, *The 'True Professional Ideal'*; Perkin, *The Rise of Professional Society*; Walkowitz, *Working with Class*.

organisms in human environments.[7] Some historians have characterized sanitarian and bacteriological approaches to public health as being virtually mutually exclusive. For example, Terry Copp, in his analysis of public health in Montréal, criticized the department's seemingly outmoded approach to public health. The fact that, in 1897, the Department consisted of a Medical Health Officer, twenty sanitary inspectors, four meat inspectors, two milk inspectors and one disinfector was evidence, in Copp's opinion, that it was "clearly operating in the tradition of the sanitary ideal."[8] However, this is a misleading oversimplification. The continued use of sanitarian principles did not preclude the incorporation of bacteriological principles into public health programs. Nor did the discovery that specific organisms caused specific infectious diseases totally supplant the use of sanitarian principles. Health officers used both approaches in their work because they produced results. Furthermore, the regulatory nature of sanitarian and bacteriological public health programs were consistent with social attitudes regarding suitable roles for men in the public sphere.

During the era when public health departments did not provide direct services to individuals and families, voluntary organizations, often managed by female social reformers, were established to meet this need. Visiting nurses were employed to provide bedside nursing care and health education programs in the homes of the sick poor. In a piecemeal fashion often dictated by local opportunities and crises, each local health

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[7]McNeill, *Plagues and Peoples*, 16, 272, 283, 287. (page citations are to the reprint edition).

[8]Copp, "Public Health in Montreal," 398.

department eventually extended its mandate to include these voluntary programs. By 1920, most large Canadian cities boasted a civic health department which, in addition to its traditional focus on sanitation and bacteriology, also offered public health nursing programs in communicable disease control, infant hygiene and school health.

Table 2-1: First Civic Public Health Nursing Programs in Selected Canadian Cities

City	Program	Date	Sponsor	Trans. to Health Dept.
Montréal	TB	1907	TB League	?
	School Inspection	1907	Montréal School Board	?
	Child Hygiene	1910	FNSJB (gouttes du lait)	1953
Toronto	TB	1905	Toronto General Hospital	1907
	School Inspection	?	Toronto School Board	1914
	Child Hygiene	1908	Pure Milk League	1914
Winnipeg	TB	1909	Anti-TB League	1914
	School Inspection	1909	Winnipeg School Board	1941
	Child Hygiene	1910	Margaret Scott Nursing Mission	1914
Vancouver	TB	1914	Anti-tuberculosis Society	1919
	School Inspection	1910	Vancouver School Board	?
	Child Hygiene	1913	VON	1920

Sources: Andrews, *The Accession of the Expert*; Baillargeon, "Gouttes de lait et soif de pouvoir"; CWA, *Health Department Annual Reports*; Defries, *The Federal and Provincial Health Services in Canada*; Gleason, "'Race, Class and Health,'"; MacDougall, *Activists and Advocates*; McMurchy, "New Field for Nurses"; Royce, *Eunice Dyke*; Zilm and Warbinek, "Early Tuberculosis Nursing in British Columbia.

The development of urban health departments was a slow process. Health officials ventured into uncharted territory by testing their legal right to use the powers of the state to protect the health of its citizens. Working in political systems based on patronage, and with politicians often more interested in their city's business opportunities than in its vital statistics, early health officers discovered that protecting the public's health was often a

thankless task. The establishment of civic public health programs in Canada is an instructive example of the challenges encountered during the long transition from the laissez-faire government of the nineteenth century to the modern welfare state.

The Establishment of the Winnipeg Health Department: 1882 - 1900

The establishment of Winnipeg's health department followed a similar process.[9] Acting on a resolution stating that "it is necessary and indispensable to appoint a Medical Health Officer," City Council appointed Dr. J. Kerr to the part time position in 1882. Council minutes and those of the Health, Relief, and Cemetery Committee indicate that there was considerable discussion concerning the terms of Kerr's appointment. His original salary of $2000 was reduced, in a subsequent meeting of the Health Committee, to $1600, "provided that the Government give $600.00 per annum." Finally, it was resolved that Kerr's salary would remain at the original figure, but that he would be obliged to pay his own assistant.[10] His duties were evidently not onerous. In addition to his responsibilities as the city's first medical health officer, Kerr was also employed as a CPR surgeon and as a health officer by the provincial government. As well, he maintained a private practice.[11] Kerr's activities during his short tenure with the city are

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[9]For a further discussion of the early years of Winnipeg's Health Department, see: Artibise, *Winnipeg*; Artibise, "Divided City," 360-391.

[10]CWA, Health, Relief and Cemetery Committee, minutes of March 17, 1882, 34; April 14, 1882, 35; Health Committee, minutes of September 2, 1882. The Health Committee minutes are contained in the Minute Book of the Market Committee, dated 1876 - 1882.

[11]Artibise, *Winnipeg*, 223.

not well documented.[12] Nor are those of the three other physicians who held this part-time post prior to 1900: Dr. W. J. Neilson (1883-1887), Dr. T. G. Phillips (1887-1893) and Dr. M. S. Inglis (1893-1900). The terms of office of all four men were marked by uncertainty, limited financial resources, political interference, and public resistance to health regulations. Despite these constraints, by 1900 they had established the fundamental structures of the city's health department.

Concerns about Winnipeg's vulnerability to outbreaks of smallpox and other communicable diseases had led to Kerr's appointment as Winnipeg's first medical health officer. These fears were in part a product of Winnipeg's increased population, in part a response to the city's worsening sanitary conditions, and in part a recognition that Winnipeg was no longer immune to regular visitations of communicable diseases imported from other cities located along major rail and water transportation systems. The first railway, from St. Paul and Chicago, had reached Winnipeg in 1878. By 1883, the CPR linked Winnipeg with Eastern Canada, and by 1885, brought regular rail traffic from Vancouver as well.[13] The incumbent medical health officer's response to disease outbreaks, particularly smallpox, was closely monitored by the Market, License and Health Committee, with interesting and seemingly contradictory results.

Dr. Neilson's successful containment of a smallpox outbreak in 1886 resulted in a

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[12] Minutes of the Market, Relief and Cemetery Committee during this period were very brief. However, they do record that he read a paper on Sanitary matters to the committee members shortly after his appointment. CWA, Health, Relief and Cemetery Committee, minutes of May 1, 1882.

[13]Artibise, *Winnipeg*, 182. For a brief description of Winnipeg's growth during this period, see: Artibise, "The Urban West," 138-166.

motion by Alderman McGee that the positions of both Neilson and the caretaker of the Quarantine Hospital be terminated, "this committee being of the opinion that their services are no longer required."[14] Neilson survived this backhanded vote of confidence. However, controversies surrounding measures to control smallpox outbreaks ended the civic careers of the city's next two medical health officers.

In 1893, Dr. Phillips became embroiled in a professional difference of opinion with Dr. James Patterson, secretary of the Provincial Board of Health, about the diagnosis of a case of smallpox and the appropriate length of time to quarantine the victim. Phillips refused to acquiesce to Patterson's order to reinstate a smallpox quarantine which he had lifted because he disagreed with the diagnosis and felt that the quarantine had imposed undue hardship on the family. Mayor Thomas Taylor's intervention in support of Patterson's position was rebuffed by Phillips. In a letter to Council dated May 22, 1893, the Mayor reported that Phillips had again refused to comply with Patterson's request that the quarantine be re-instated. Taylor also reported that Phillips had made several inflammatory remarks about Patterson's professional competence, and had expressed his satisfaction that an opportunity had arisen to have the validity of the current small pox quarantine regulations tested in the courts. Although the Market, License and Health Committee initially supported their recalcitrant medical officer, Phillips was ultimately forced to resign.[15]

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[14]CWA, Health and Relief Committee, minutes of March 19, 1886, 104.

[15]CWA, Communications to Council, Letter #2349. See also: CWA, Market, License and Health Committee, minutes of June 21, 1893, Item 307; June 26, 1893, Item 310; October 11, 1893, Item 388.

Dr. Inglis was fired by City Council in July, 1900 in the aftermath of another smallpox outbreak.[16] A rancorous dispute between Inglis and Alderman Harvey, a member of the city's Finance Committee, culminated in the Committee's refusal to pay Inglis's expenses related to his being quarantined with the patients at the temporary smallpox hospital during the outbreak. Because he had been appointed by Council, Inglis insisted that the matter should be decided at a Council meeting. He accused Harvey and the *Manitoba Free Press* of spreading rumours that there were financial irregularities in his expense accounts, and also of implying that Inglis had put the city at risk by temporarily leaving the hospital to provide consultation services for suspected cases of smallpox. Mayor Wilson, stung by accusations that he had also been involved in the alleged financial irregularities, resisted efforts by members of Council to dispense with the medical health officer's services. However, Inglis's career with the city was over.[17]

Winnipeg's early health officers also initiated the establishment of major sanitary projects. When the rapid influx of settlers and immigrants set off the construction boom of the late nineteenth and early twentieth century, real estate speculators focussed on the immediate need and on the opportunity for quick profits. The construction of houses took precedence over the creation of a sanitary infrastructure to cope with Winnipeg's burgeoning population. In 1890, only ten percent of the city's houses had sewer and water connections. These households were concentrated in the more affluent southern suburbs of the city. By 1902, connections had been made to only thirty-three percent of city

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[16]Carr and Beamish, *Manitoba Medicine,* 65.

[17]"Health Officer and Council," *Manitoba Free Press*, July 31, 1900, 6.

homes. Wards 4, 5, and 6, located in the city's (in)famous North End, had no sewer or water mains at all. In this district, the land had been subdivided into residential lots as narrow as 25 feet in width. Outdoor privies were the norm. There was no space inside the houses to add indoor sanitary plumbing fixtures, and no room between the houses to facilitate connection to water and sewer mains. This lack of foresight meant that when health officers insisted on the provision of sanitary improvements in the North End, compliance with the by-law was an expensive, time-consuming, and disruptive process.[18]

Although the individual careers of Winnipeg's early medical health officers hinged on their performance during epidemics, their legacy to the city was far more significant. Collectively, they convinced a reluctant and somewhat sceptical city council that public health was a civic responsibility. By 1900, in addition to organising quarantine and disinfection procedures during outbreaks of communicable diseases, the health department supervised the private contractors responsible for the city's street scavenging and garbage disposal system, and inspected the city's food and water supply. It boasted six full time employees, including two Health Inspectors, two Assistant Inspectors, one Dairy Inspector and a clerk.[19]

These achievements were solidified by the appointment of Alexander J. Douglas as Winnipeg's first full time medical health officer on September 10, 1900.[20] A graduate of the Manitoba Medical College with postgraduate training in Europe, Douglas was

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[18]Artibise, *Winnipeg*, 22, 130-131, 150-172, 226-272.

[19]CWA, Council Minutes, 1900. Estimates for the 1900-1901 Fiscal Year.

[20]CWA, Council Minutes, September 10, 1900.

twenty-six years old at the time of his appointment. He retired in 1939 as Winnipeg's longest serving civic employee.[21] A pioneer in the emerging cadre of professionally trained civil servants, Douglas was acutely aware of the perils of his post.

> [W]hen I first took office, the health officer, in my community at least, was looked upon by most people as a rather unnecessary appendage to the municipal pay-roll - not only unnecessary, but very often pernicious, for sometimes he had the temerity to interfere with citizens, particularly the so-called best citizens' inalienable right to do as they please. . . . It was considered that his proper sphere was to supervise the collection of city wastes, to keep the streets clean, to juggle with statistics (always with a view to emphasizing the salubrity of his own locality), and to occasionally show some activity during outbreaks of the more serious communicable diseases. . . . He was always to use discretion as to whose toes he trod upon; he was not to point out glaring sanitary defects in his community as this spoiled business and kept visitors away.[22]

By all accounts, Douglas was up to the challenge. He solidified and extended the programs established by his predecessors. In addition, he supervised the establishment of Winnipeg's first permanent quarantine hospital, participated in the establishment of a safe water supply for the city, organized a civic scavenging department, enforced new by-laws which required that public buildings and private dwellings be connected to Winnipeg's water and sewage systems, and virtually eliminated the outdoor privy within the city limits.[23] A particularly momentous occasion, the closure of the last box closet in

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[21] *Winnipeg Free Press*, April 21, 1939; Legislative Library, Province of Manitoba, Biographical Files B9.

[22] Douglas, "Chairman's Address," 85-86.

[23] For a more detailed account of these accomplishments, see: Artibise, *Winnipeg*; Artibise, *Gateway City*.

Winnipeg, was jubilantly noted in the Department's 1909 Annual Report.[24] A photograph of the offending structure was included in the report.

The vocal and often well organized opposition with which these measures were met often frustrated the efforts of public health officials. A case in point is public resistance to city by-laws requiring that new and existing dwellings be hooked to water and sewer mains on all streets where these facilities were available. The correspondence and minutes of the Market, License and Health Committee reveal that some citizens resisted the imposition of the by-laws. Many individual homeowners could not afford to make the required connection, and requested exemption from the by-law or an extension of the time within which to comply.[25] In order to assist householders who could not afford to pay for water and sewer connections outright, City Council, in 1905, enacted a policy that enabled them to spread the cost over five years. Other homeowners, more suspicious of these civic incursions into the organization of their household, simply moved themselves and their houses outside the city limits. A favourite destination for those intent on evading the city's sanitary regulations was West Kildonan, which was located

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[24]Outdoor privies were divided into three categories. The least sanitary was the box closet, which was simply a box located under the toilet seat into which human waste was deposited. It had to be emptied on a regular basis by someone willing to actually pull out and empty the box. Earth closets were slightly more sanitary. Human waste was deposited into an earth pit, which could be pumped out or covered with earth once it was too full to use. The most satisfactory privy, and the one which Douglas preferred home owners to use until sewer connections could be made, was the brick pit. In addition to the other 'advantages' offered by the earth closet, the brick pit could be made impervious to water. This prevented human waste from leaching out into the surrounding soil.

[25]Artibise, *Winnipeg*, 234.

immediately adjacent to Winnipeg's predominantly working class North End.[26]

Landlords could be particularly troublesome, both to city officials and to their tenants. Some elected to pay fines rather than incur the greater expense of complying with the by-laws. Others made the connections as required by the city, but did not install indoor toilets or sinks for their tenants.[27]

The necessity for "persistent" follow up on orders to connect to water and sewer mains reveals that the goal of having every building in Winnipeg connected to a safe water supply and a sanitary sewer system entailed far more than simply putting the pipes in the ground.[28] Competing economic interests, overlapping political mandates, scientific disagreements, and consumer resistance played a role in shaping the development and nature of public health interventions both in Winnipeg and elsewhere.

A Brief History of Visiting Nursing

At the turn of the twentieth century, in addition to the sanitary and bacteriological programs provided by male dominated local health departments, voluntary organizations founded by female social reformers provided visiting nursing services to individuals and families in their homes.[29] The origins of Canada's district/visiting nursing associations are

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[26] Working class resistance to civic improvements such as water and sewer connections, and other public health measures, including compulsory vaccination, is extensively discussed in an unpublished paper. See: FitzGibbon, "The People's Health."

[27] Artibise, *Winnipeg*, 234.

[28] Douglas uses this word to describe the Department's efforts in enforcing the city by-laws in his 1908 Annual Report. See: CWA *Health Department Annual Report*, (1908): 10.

[29] Fee, "Public Health and the State," 234.

found in Liverpool. In 1859, William Rathbone employed a trained nurse, Mary Robinson, to provide both bedside nursing care and health instruction in the homes of the sick poor. It was hoped that these services would alleviate the suffering of the poor and contribute to their moral reform. Although a difficult experience for Robinson, who was shocked by the living conditions of the families she visited, the experiment was a success. As more nurses were recruited and trained, the city was divided into districts and a nurse assigned to provide nursing services within each district. Rathbone's financial support enabled district nursing services to be extended to the entire city. In 1875, the Metropolitan and National Nursing Association introduced the Liverpool model to London. The Association, later re-named the Queen's Institute of District Nursing, became the central training centre for visiting nurses in Britain.[30] It also inspired the formation of similar organizations in both the United States and Canada.

British district nursing services and their sister visiting nursing organizations in Canada and the United States predated the employment of public health nurses by government health departments. Visiting nurses pioneered many of the programs now commonly incorporated into the practices of public health nurses. In the words of Adelaide Nutting, public health did not invent the public health nurse, it found her already at work in the district "nursing the sick, watching over their families and the neighborhood, and teaching in the homes those sanitary practices, those measures of

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[30]Buhler-Wilkerson, *No Place Like Home*, 18-22; Buhler-Wilkerson, *False Dawn,* 1-12; Emory, *Public Health Nursing in Canada,* 21-24; Fitzpatrick, *The National Organization for Public Health Nursing,* 3-5

personal and home hygiene which do much to prevent disease and promote health."[31] The National Organization for Public Health Nursing (NOPHN), the American umbrella organization for local visiting nursing associations, included in the mandate of the visiting nurse communicable disease control, child welfare programs, health teaching, school nursing, medical social service, and industrial nursing as well as the provision of bedside nursing care to the sick.[32] However, bedside nursing was the primary focus of visiting nursing organizations because the leadership of the NOPHN feared that priorizing health education and preventive work would result in the sick poor being left to the mercies of untrained caregivers.[33] Considerable variation existed in the range of preventive and social reform programs offered by American and Canadian visiting nursing associations. What unified them was their focus on the care of the sick.

Visiting nurses generally worked six days a week, making only emergency visits after hours and on Sunday. They usually worked alone, setting out from their agency headquarters in the early morning with a list of the calls planned for that day. In the early years, visiting nurses used public transportation to travel to their districts, and then walked to homes located at a distance from the street car routes. By the 1920s, cars were purchased by some of the larger and better funded urban agencies.[34] Although the costs

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[31]Nutting, "Thirty Years of Progress in Nursing," 1027-1030.

[32]Fitzpatrick, *The National Organization for Public Health Nursing*. See, in particular, Chapter 1.

[33]Fitzpatrick, *The National Organization for Public Health Nursing,* 12.

[34]Penney, *A Century of Caring,* 53, 57.

associated with the use of automobiles were significant, the efficiencies gained by reducing time lost waiting for public transportation and the money saved by avoiding taxi fares for emergency night calls appear to have made the capital investment worthwhile.[35]

In a typical day, the visiting nurse made anywhere from eight to twelve visits.[36] The average number of visits per day did not change significantly over time. At the turn of the twentieth century, visiting nurses worked very long hours to complete their daily rounds. By the 1940s, when the eight hour day was becoming the standard, more efficient transportation had reduced the time per visit to less than one hour.[37]

Visiting nurses generally visited their most seriously ill patients at the beginning, and sometimes again at the end, of their working day.[38] In addition to the provision of nursing care, nurses also performed domestic duties in the homes of their patients. They lit fires, tidied rooms, prepared meals, and washed dishes to ensure the comfort of the patient. Instructions regarding the ongoing care of the patient were given to spouses, older children, or even neighbours of the patient.[39] In the early twentieth century, the majority

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[35]In the 1940 Annual Report of the Winnipeg Branch of the VON, the District Superintendent attributed the increase of 3061 visits over the previous year primarily to improved transportation rather than to the addition of one staff nurse. VON, Manitoba Branch, *Annual Report* (1940), 15-16.

[36]Buhler-Wilkerson, *False Dawn,* 28.

[37]VON, Manitoba Branch, *Annual Report* (1940): 14.

[38]Buhler-Wilkerson, *False Dawn,* 28; VON, Manitoba Branch, minutes of October 15, 1924.

[39]Vivid descriptions of the visiting nurse's work appear in newspaper accounts of the founding of the Margaret Scott Nursing Mission. The November 12, 1904 edition of the *Manitoba Free Press* contains a detailed description of Miss Lamont's work as the

of nursing visits were made to pregnant, labouring, and postpartum women. After hospital based obstetrical care became the norm, even for poor women, those receiving visiting nursing services included the elderly, the convalescent, and the chronically ill.[40]

Early visiting nursing associations rarely provided care to those suffering from communicable diseases. The only exception to this rule was tuberculosis cases. Until responsibility for tuberculosis nursing was undertaken by voluntary anti-tuberculosis organizations and/or health departments in the early twentieth century, visiting nursing associations frequently reported tuberculosis patients in their caseloads.[41] However, contact with infectious cases was a serious problem for visiting nurses because their reputations depended upon the avoidance of cross-contamination between patients.[42]

Once their bedside nursing obligations were fulfilled, visiting nurses could turn their attention to the many other programs and services which might be offered by their agency. These duties varied widely from one agency and community to another, and changed over time. In some communities, public health programs replaced services pioneered by visiting nursing associations. In others, visiting nursing organizations either entered into contractual arrangements with local health departments to provide these

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city district nurse and a verbatim report of Isabel M. Stewart's paper describing her experiences as Miss Lamont's summer replacement. See Appendix 1 for these accounts.

[40]Penney, *A Century of Caring,* 68.

[41]Buhler-Wilkerson, *No Place Like Home,* 56; Penney, *A Century of Caring,* 43. Part of the reason that tuberculosis patients were carried on the case loads of visiting nursing associations was that, in the early twentieth century, tuberculosis was not classified as a contagious disease.

[42]Buhler-Wilkerson, *No Place Like Home,* 56-59.

services or continued to provide them on their own initiative.

Unlike the United States, where independent visiting nursing associations were established in local communities and affiliated through the NOPHN, Canada possessed a national visiting nursing organization. The Victorian Order of Nurses for Canada was founded in 1897 by Lady Aberdeen, wife of the Governor-General, to provide skilled nursing care in the home to individuals and families who were unable to avail themselves of the services of private duty nurses. The National Council of Women, of which Lady Aberdeen was the first President, had a particular interest in ensuring that nursing services should be made available to those "living in the North West Territory and in outlying districts of Canada."[43] The idea of urban VON branches was an afterthought, initiated after the organizing committee learned that the need for skilled nursing care in large urban centres was as urgent as that experienced in Canada's rural and territorial districts.[44] A second objective of the Order was to "assist in providing small Cottage Hospitals or Homes."[45] Cottage hospitals were a collaborative venture between local communities and the VON Central Board. Local communities provided the buildings and managed the facilities. The Central Board provided nurses and, if necessary, assisted in the furnishing of the hospital. In the long run, local communities were expected to undertake complete financial and administrative responsibility for their hospital.

Local VON Branches established their own administrative structures and raised

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[43]Penney, *A Century of Caring*, 15.

[44]Penney, *A Century of Caring*, 15.

[45]*Provisional Constitution: The Victorian Order of Nurses in Canada*, 5.

the necessary funds in their local community. The first Local Branch was established in Ottawa in 1898. The following year, Toronto, Halifax, and Montreal followed suit. By 1900, a total of nine Local Branches had been established in Eastern Canadian cities as well as a short-lived branch in Vancouver.[46] Throughout its history, the establishment of Local Branches was almost entirely an urban phenomenon. Providing district nursing services to rural Canadian communities was a much more challenging enterprise and one which was never satisfactorily achieved.[47]

Visiting Nursing in Winnipeg: The Early Years: 1897 - 1904

Winnipeg's first district nurse, Frances Baker, was appointed by the Winnipeg General Hospital in July 1897. The Hospital paid her salary and made her services available to the city medical health officer to visit patients who needed nursing care, but who, for a variety of reasons, could not be admitted to the General Hospital. Because these duties did not take up all of her time, Baker also received referrals from the hospital's outdoor (outpatient) departments. The majority of her patients were women and children.[48] Baker resigned in October of 1898, and was replaced by Louise M. Clark,

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[46]Sheila Penney states that the Vancouver Branch, "discouraged by workload and financial worries" closed in 1899. According to John Gibbon, the Vancouver Branch was re-established in 1912. See: Penney, *A Century of Caring,* 27; Gibbon, *The Victorian Order of Nurses for Canada*, 116-119.

[47]Richardson, "Political Women, Professional Nurses," 29.

[48]NAA WGH/HSC Archives, Winnipeg General Hospital, *Annual Reports* (1897): 6-7, 32.

another graduate of the General Hospital School of Nursing.[49] In June 1901, the hospital discontinued its financial support of the district nurse.[50] Although the hospital did not explain its action, the facility's annual report for 1900 stated that when the district nurse went on leave for five months during the summer, there was not enough work to warrant hiring a replacement.[51] Other sources state that the hospital was unable to afford to continue this service.[52] After the termination of the General Hospital's district nurse service, Margaret Scott, a lay church missionary, attempted to fill the gap by providing whatever assistance she could to the sick in addition to her other philanthropic work.

Scott had begun her work amongst Winnipeg's poor in the late 1880s.[53] Initially, she assisted the Rev. C. C. Owen, rector of Holy Trinity Church, with his correspondence in relation to the plight of Winnipeg's growing number of poverty-stricken families and individuals, a steadily-growing percentage of whom were recently arrived immigrants. Scott became increasingly committed to this work, and eventually left her full-time employment as a stenographer to devote her life to the alleviation of their suffering. By 1898, she was living in a small room above the Winnipeg Lodging and Coffee House on

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[49]NAA WGH/HSC Archives, Winnipeg General Hospital, *Annual Reports* (1898): 37.

[50]AM. The Mission papers, MG 10, B9, Box VI. *Annual Report* (1935): 4.

[51]NAA WGH/HSC Archives, Winnipeg General Hospital, *Annual Reports* (1900): 46.

[52]*Manitoba Free Press,* "Margaret Scott Nursing Mission Meeting in Y.M.C.A. Resulted in Expansion of Old Benevolence on New Lines," May 17, 1904.

[53]MacVicar. *Margaret Scott*; NAA WGH/HSC Archives, *Blue and White* (1932), 13; *Manitoba Free Press*, Jan. 18, 1975.

Lombard Ave., and entirely dependent on charitable donations both for her own personal needs and for the money, food, clothing, and other necessities which she distributed to others. Scott never accepted a salary for her work, and trusted that, through the generosity and commitment of other Christians, God would sustain her work.

In 1901, E. H. Taylor, a Winnipeg businessman and philanthropist, offered to pay the salary of a nurse to assist Scott in her work.[54] Annie S. Rathbone, a graduate of Massachusetts General Hospital, was employed to work with Scott. She apparently also lived at the Coffee House.[55] In 1902, Taylor persuaded the City of Winnipeg to pay half of Rathbone's salary.[56] After that date, the city's Market, Licence and Health Committee received regular monthly reports from Rathbone until her resignation in November, 1902. Her successor, Eliza Lamont, continued to submit regular reports to the Committee.[57] After Taylor's death in 1903, the city included the full salary of the district nurse ($600 per annum) in the health department budget.[58] However, the city only funded its own city nurse for a period of one year. In 1904, the Margaret Scott Nursing Mission was founded

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[54]Macvicar, *Margaret Scott,* 8-10.

[55]Macvicar, *Margaret Scott,* 8-10; *Manitoba Free Press*, "Margaret Scott Nursing Mission Meeting in Y.M.C.A. Resulted in Expansion of Old Benevolence on New Lines" May 17, 1904.

[56]CWA, Market, Licence and Health Committee, minutes of January 21, 1902, Item 325.

[57]CWA, Market, Licence and Health Committee, minutes of November 15, 1902, Item 641, December 10, 1902, Item 673.

[58]A budget line for a District Nurse first appears in the 1903-1904 estimates for the City of Winnipeg Health Department.

by a group of Winnipeg women interested in supporting Scott's work. At this point, the city health department turned over responsibility for its city nurse to the Mission. From that time, civic authorities provided an operating grant to "the ladies" to support their visiting nursing program. The seemingly effortless manner with which the transfer of responsibility for visiting nursing services in Winnipeg was accomplished is perhaps an indication of consensus on both sides that women were more suited to the business of providing direct nursing care to the sick in their own homes than were the city's health officials.

Conclusion

One of the most vivid images of pre-First World War Winnipeg is that of a city whose civic pride and sense of destiny far outstripped both its size and its achievements. The city's social and political elite have been described as unrepentant boosters more interested in furthering Winnipeg's (and by extension, their own) business interests than in providing assistance to the legion of impoverished newcomers who eked out a miserable existence in the city's "poorer districts."[59] It is true that much more could have and perhaps should have been done to relieve the suffering of those who had contributed to Winnipeg's business success and yet had not shared in the resulting prosperity. However, Winnipeg's record in developing a public health system during this era must be evaluated within the context of the achievements of comparable cities in Canada and the United States. From this perspective, Winnipeg emerges as a city that recognized

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[59]See, for example: Artibise, *Winnipeg*; Artibise, *Gateway City*; Artibise, "Boosterism and the Development of Prairie Cities," 515-543.

relatively early in its existence that public health and visiting nursing programs were necessary to the city's future success. However, like other cities of the time, these programs were a priority only during times of crisis.

In Winnipeg, political beliefs about the role of civic governments, and social beliefs about the appropriate roles that men and women could perform in the public sphere constrained the vision of city bureaucrats and female social reformers alike. Thus, men were confined to the development of public health services that were, literally, public. Their scope of influence was limited to the city streets, the construction of buildings, and the sale of food and milk in the marketplace. The domestic spaces of Winnipeg's citizens were an alien territory which the social customs of the time did not allow them to enter. Women, however, because of their moral authority in the domestic sphere, could and did enter the homes of the poor. In the process, they opened up a separate, but equally important approach to the provision of public health services in the city.

Chapter 3

The Winnipeg Health Department's Campaign to Regulate the City Milk Supply, 1894-1922

Introduction

The first initiatives to reduce the appalling mortality rates experienced by Winnipeg's citizens included the development of sanitary infrastructure such as water and sewage systems, and the passage and enforcement of legislation regulating the construction of houses and public buildings, the sale and distribution of food, and the control of communicable diseases. The controversial campaign to secure a safe water supply, a familiar chapter in the city's history, is one example of the emphasis that health officials placed on sanitation to reduce mortality from communicable disease. Complaints about both the quality and the quantity of the city's water supply were a familiar refrain by the end of the nineteenth century. In 1900, City Council bought out the privately owned Winnipeg Water Works Co., established an artesian well system and laid more water mains. However, the water supply was still inadequate, and the fire department often had to draw water from the polluted Assiniboine River into the city's water mains to fight fires. After a typhoid epidemic in the fall of 1904, which followed close on the heels of a major fire, efforts began in earnest to replace the existing water system. In 1913, the ambitious decision was made to build an aqueduct stretching 156 kilometres from Shoal Lake to bring an ample supply of clean, safe water to the city.[1] The campaign to place Winnipeg's water supply under the city's control was organized, funded, enacted,

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[1]Artibise, *Winnipeg,* 207-222; Artibise, Gateway City, 179-190.

and resisted primarily by male politicians, professionals, and businessmen. Although one cannot fully discern the impact that women's opinions on these matters might have had within the confines of family and social networks, their participation in public debates about Winnipeg's water supply was severely constrained because, except in very rare instances, they could not vote and did not hold elected offices.

Winnipeg's effort to clean up its milk supply is less well known. The regulation of the production and sale of fresh milk, a matter which had previously been a transaction between individual producers and consumers, broke new ground for both politicians and health officials. New legislation conferred the necessary powers upon city officials and the health department created new structures to fulfil the mandates created by these laws. Dairy producers exerted unexpectedly powerful resistance to the regulation of their industry, creating contentious debates about the limits to free enterprise on the one hand, and the authority of local governments to regulate on the other.

Professional men, primarily physicians and veterinarians, participated enthusiastically in debates about how Winnipeg's milk supply could best be rendered safe for human consumption. Both groups sought to consolidate their tentative grasps on influential positions within the city health department, and to attain similar positions in departments of health and agriculture at the federal and provincial levels by demonstrating that they possessed the most accurate scientific knowledge to develop strategies to protect the public's health.

Women, too, were drawn into the debate. However, their participation was not solicited in order to clarify the scientific debates or to assist in the development of dairy

regulations. Women's participation was based on their role as milk consumers. This distinction not only separated them from the male politicians, health officials, physicians, veterinarians, and dairy producers who actively proposed or resisted the imposition of dairy regulations. It also reinforced women's limited political role and highlighted the social expectation that, in the performance of their domestic responsibilities, they would be a source of moral guidance for men.[2]

Health officials believed that women could serve as a powerful pressure group to force dairy producers into conforming with city health regulations, and to force provincial politicians to pass legislation requiring that all milk sold in the city be pasteurized. An educational campaign was organized to convince the city's housewives that the health of their children and loved ones hung in the balance. Although city health officials believed that the dairy regulations would garner the unqualified support of the "ladies," such was not the case. Women were also divided along class and ideological lines. Influential physicians convinced many middle class women that pasteurized milk was unsafe for infants and children. Some working class women, particularly those with close connections to the labour movement, viewed both city health officials and the city's creameries with considerable suspicion. They believed that regulation of the dairy industry and mandatory pasteurization of milk conferred the greatest financial benefits on the capitalists and politicians orchestrating the clean milk campaign. Women's opinions were also shaped by the cost of milk and the extent to which public health measures put

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[2]For an extended discussion of women's role as consumer, see: Bowlby, *Just Looking*, particularly the Introduction.

additional pressure on the household budget.

This chapter, then, analyses Winnipeg's clean milk campaign in greater detail. It argues that, in the gendered division of labour characteristic of the early public health movement, men were directly involved in regulatory strategies because they had access to the necessary political power. It also explores the extent to which professional aspirations divided the medical community, leading medical health officers to disagree with their colleagues in private practice, and to favour regulatory strategies more consistent with those recommended by veterinarians. It also examines the impact that differing professional opinions had on the evolution of dairy policies and regulatory strategies enacted during this era. Finally, women's participation in the clean milk campaign is examined. It will be argued that although gender was an important factor in determining the manner in which women were drawn into the public debate, their opinions about the regulation of the dairy industry and the creation of a safe civic milk supply were more likely to be shaped by other affiliations and priorities. As a result, their response to the clean milk campaign was as divided as was that of their male counterparts.

The Pure Milk Movement

The Winnipeg health department's efforts to create a safe civic milk supply can only be understood within the context of the vigorous scientific debate which preoccupied bacteriologists, physicians, health officials, and interested members of the public during the late nineteenth and early twentieth century. The first was the debate about whether or not *Mycobacterium bovis* (*M. bovis*), the causative organism for tuberculosis in cattle, could be transmitted to humans through the consumption of infected meat and milk. The

second was whether or not the universal pasteurization of milk should be enforced to reduce infant mortality rates from tuberculosis and other milk borne pathogens.

Robert Koch, who identified the causative agent for human tuberculosis (*M. tuberculosis*) in 1882, initially believed that the human and bovine forms of the disease were virtually identical.[3] Indeed, there was general agreement in the medical and scientific communities that *M. bovis*, when ingested in contaminated meat and milk, could produce non-pulmonary tuberculosis in humans, particularly in children. It was estimated that upwards of 25 percent of all childhood cases of tuberculosis were caused by *M. bovis*.[4]

In 1901, Koch announced that he had reversed his previous position, and was now convinced that humans were only rarely infected with *M. bovis*.[5] At the International Tuberculosis Congress, held in Washington in 1908, Koch became embroiled in a contentious debate about the etiology of tuberculosis in humans. A. J. Douglas, Winnipeg's medical health officer, who attended the Congress at the behest of Winnipeg City Council, had this to say about the debate:

> This year he somewhat modified his view and stated that while bovine and human tuberculosis were different diseases, yet sometimes bovine tuberculosis did attack the human organism, but its results were never serious, the infection being confined practically to the lymphatic glands, and it never caused consumption.
> This view was vigorously opposed, almost all the prominent pathologists

[3]Brock, *Robert Koch,* 254.

[4]Hastings "The National Importance of Pure Milk."

[5]Brock, *Robert Koch,* 254-55; McCuaig, *The Weariness, the Fever and the Fret,* 158.

> and bacteriologists present assailed Professor Koch's position and endeavoured to show that the bovine type of the bacillus was responsible for a very large proportion of the tuberculosis that affects man.
> After a stormy session, the consensus of opinion was that animal tuberculosis is [underline in original] transmissible and is particularly efficacious in causing glandular, intestinal and joint tuberculosis, and possibly tubercular meningitis, and that steps should be taken to control as far as possible the disease in animals.[6]

Koch also refused to endorse the universal pasteurization of milk to prevent the transmission of tuberculosis from cattle to humans. His position on the link between human and bovine tuberculosis had profound implications for public health officials, private physicians, and veterinarians, all of whom had a professional interest in tuberculosis prevention and the campaign to clean up the milk supply.[7]

The majority of public health officials, who had, in the previous decade, mounted expensive and controversial campaigns to reduce infant mortality rates through the eradication of bovine tuberculosis in dairy herds and the pasteurization of milk, believed that Koch was wrong.[8] Regulation of the milk supply was an important strategy for

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[6]CWA, Health Committee Communications, October 27, 1908, Item 1096. The document is an eight page report, written by Douglas, on the Tuberculosis Congress.

[7]Koch's announcement precipitated the organization of two national commissions of inquiry into the relationship between human and bovine tuberculosis. The German Commission, after nearly three years of deliberation, concurred with Koch's position. The British Royal Commission took ten years to conclude that human and bovine tuberculosis were essentially the same disease. Brock, *Robert Koch,* 255; Spargo, *The Common Sense of the Milk Question*, 225; Worboys, *Spreading Germs*, 221-225. Douglas provided a summary of the Commission's findings in the Health Department's monthly *Bulletin.* See: "Report of the Royal Commission on Tuberculosis."

[8]This belief was reinforced by the unanimous conclusions of two British Royal Commissions - the 1895 Commission on the Effect of Food derived from Tuberculous Animals upon Human Health, and the 1898 Commission on Controlling the Danger to Man Through the Use as Food of the Meat and Drink of Tuberculous Animals - that a

medical health officers, who were engaged in a professional struggle to consolidate their authority over the emerging discipline of public health. Prior to the late 19th century, it was not unusual for engineers or even well educated lay persons to be appointed to leadership positions in public health. The new science of bacteriology provided physicians with the opportunity to consolidate their grasp on these increasingly prestigious and influential positions. Creating and enforcing regulations built upon the science of bacteriology, as set out in dairy by-laws, placed medical health officers front and centre in efforts to control the spread of tuberculosis in their communities.

Veterinarians were also engaged in a struggle to establish their professional sphere of influence. They supported the scientific opinion that bovine tuberculosis could be transmitted to humans and argued passionately for the use of the tuberculin test to eliminate tuberculosis in dairy herds. The anti-tuberculosis campaign was an opportunity for these men to carve out a sphere of influence in the emerging fields of animal health and public health.[9] Success in this professional project enabled veterinarians to solidify their grasp on influential positions in federal and provincial health departments as experts in animal health and, by extension, the protection of human health.

Unlike veterinarians and medical health officers, private physicians were divided in their opinion about the role that *M. bovis* played in the etiology of human tuberculosis,

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large proportion of human tuberculosis was caused by drinking contaminated milk. See: Spargo, *The Common Sense of the Milk Question*, 124-129.

[9]Rosenkrantz. "The Trouble With Bovine Tuberculosis."

particularly in children.[10] They were also divided as to whether tuberculin testing and pasteurization were scientifically sound solutions to the problem. Some opposed the use of the tuberculin test in dairy cattle. Its efficacy in this application was overshadowed, in their minds, by its abysmal failure in the treatment of human tuberculosis.[11]

Many other physicians, particularly those practising in the new field of pediatrics, believed that pasteurized milk was unsuitable for infants and children because the process altered the chemical composition of milk.[12] They also feared that pasteurization would lead to complacency and unsanitary milk production on the dairy farm.[13] Anxious to assume a leading role in protecting the health of the nation's children, these physicians believed that the best way to produce a pure milk supply was to ensure that the highest possible hygienic conditions were maintained in dairies. Physician-led milk commissions were established throughout Canada and the United States to encourage the production of certified milk by stringently supervised dairies.[14] Certified dairies were overseen by veterinarians, who tested the herd semi-annually for tuberculosis, by physicians who examined all employees monthly, and by bacteriologists, who regularly tested milk

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[10]Koslow. "Putting It To A Vote."; Rosenkrantz. "The Trouble With Bovine Tuberculosis,"155-175.

[11]Worboys, *Spreading Germs*, 225.

[12]Meckel, *Save the Babies*, 81-82.

[13]Spargo, *The Common Sense of the Milk Question*, 250-253.

[14]See: Spargo, *The Common Sense of the Milk Question,* 250-253. Spargo was an advocate of certified milk and supported pasteurization only as a stop gap measure until more hygienic milk production could be assured.

samples for the presence of bacterial contamination. Milk from certified herds was believed to be tuberculosis free and, if not contaminated while being handled on the farm or while being delivered to the consumer, was also believed to be free of other pathogens. By establishing milk commissions, the medical community vested itself with the authority to oversee the production of a safe milk supply. This strategy bolstered organized medicine's goal of being the sole source of expertise related to the preservation of human health, particularly the health of children.

The scientific debate about the role that *M. bovis* played in the etiology of human tuberculosis and professional disagreements about the best methods to eliminate this pathogen from the milk supply had unfortunate consequences. Because of lay and medical opposition to pasteurization, public health officials were reluctant to insist on the universal pasteurization of the milk supply. Dairy regulations were enacted which allowed raw milk from certified herds to be marketed within city limits. However, certified milk did not solve the problem of infant mortality. It was significantly more expensive, and most health officials freely admitted that "the high cost of production will prevent its ever being extensively used in any municipality."[15] As well, in an era where a significant proportion of dairy cattle were infected with tuberculosis, there was no guarantee that certified herds would remain disease free.[16] Finally, certified milk was still raw milk. Low bacterial counts alone could not preclude the risk that some of the bacteria

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[15]Hastings, "Report of the Medical Officer of Health," 14.

[16]Hastings, "Report of the Medical Officer of Health,"15. Hastings cites several instances where certified tuberculosis free dairy herds were subsequently found to have high infection rates.

present were human pathogens, including typhoid fever, diphtheria, scarlet fever, septic sore throat, and cholera infantum (summer diarrhea).[17] Only the pasteurization could reduce the incidence of tuberculosis and the other milk-borne infections contributing to infant mortality.

Regulating "Those Dirty Dairies": M. S. Inglis and the Dairy By-Laws, 1894 - 1900

On January 3, 1894, two months after his appointment as Winnipeg's medical health officer, M. S. Inglis initiated the city's first organized effort to regulate the quality of its milk supply.[18] Empowered by enabling provincial legislation, the Market, License and Health Committee drafted a by-law to eliminate the risks to health posed by contaminated milk. Broadly speaking, contamination of the milk supply occurred in two ways: adulteration and bacterial contamination. Milk was adulterated through the addition of preservatives, colouring agents, or water.[19] Adding water, which increased the volume of milk while lowering its nutritional value, was a common practice at that time. James

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[17]Spargo, *The Common Sense of the Milk Question,* 120-150; Hastings, "The National Importance of Pure Milk:" Hastings, "Report of the Medical Officer of Health." Septic sore throat is caused by Group A (Beta Hemolytic) Streptococcus. If not properly treated with penicillin, which was not available until after the Second World War, a case of 'strep throat' could progress to scarlet fever and the development of rheumatic heart disease. See: Chin, *Control of Communicable Diseases Manual*, 470-476.

[18]Winnipeg's first efforts to regulate its milk supply were on pace with similar efforts in other Canadian and American cities. Milwaukee passed its first ordinance in 1887, and Toronto began to regulate its milk supply in 1893. Los Angeles had an ordinance prohibiting the adulteration of milk as early as 1874, but did not employ city officials to enforce it until 1889. See: Koslow, "Eden's Underbelly," 23; Leavitt, *The Healthiest City,* 169; MacDougall, *Activists and Advocates,* 97.

[19]For a discussion of some of the chemicals commonly added to milk, see: See: Spargo, *The Common Sense of the Milk Question*, 168-173.

French, a frequent correspondent to Council, wrote two letters complaining about "thin, blue-white" milk delivered to his boarding house, and recommended that the city employ a milk tester to discourage the practice of watering milk. "This wishy-washy kind of milk and water" he observed, "clearly demonstrated that union is not always strength."[20]

Bacterial contamination also threatened the purity of the milk supply. It occurred in several ways, including the use of contaminated water to adulterate milk, the use of diseased dairy cows in milk production, the production of milk in unhygienic dairies, and the introduction of bacteria through careless handling of milk both at the dairy and during delivery to the householder. In the virtually unregulated marketplace of the late nineteenth century, many of Winnipeg's dairies could be accurately described as a threat to the public's health.[21]

Inglis's first attempt to regulate Winnipeg's milk supply was designed to eliminate both the adulteration of milk and its bacterial contamination [Table 3-1]. Although the By-Law did allow the city's Medical Health Officer to inspect dairies and dairy cattle, it was silent on the issue of what powers the city might have to eliminate diseased cows from dairy herds.[22] Its passage apparently met little resistance from milk producers and vendors. However, this situation soon changed.

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[20]CWA, Communications to Council. His first letter, dated May 13, 1889, is filed in the Council Letter Register (#1146). His second, # 1267, is not on file.

[21]In 1895, the *Manitoba Free Press* ran two articles on the filthy conditions found in some of Winnipeg's dairies. See: "Inspection of Dairies" *Manitoba Free Press*, January 1, 1895, 8; "Those Dirty Dairies" *Manitoba Free Press*, April 1, 1895, 4.

[22]The by-law only specified that the milk from diseased animals was not to be mixed with other milk, or sold as human food. See: CWA, By-Law 721, Clause 8.

Table 3-1: City of Winnipeg Dairy By-Laws 1894-1922

By-law/Date	Provisions Added/Refined	Response/Result
By-law 721 June 1894	1. License to sell milk 2. Health Officer (HO) keeps register 3. HO shall inspect premises whether inside or outside city 4. Proper building for dairy/cow shed 5. Persons suffering from disease to have no contact with milk or cattle 6. Cowshed/milk store not to be used as sleeping quarters 7. No other animals in cowshed 8. HO to be notified if cattle diseased/milk not to be used 9. Butter and cheese makers need not be licensed 10. Owners of one cow need not be licensed, but cow to be inspected 11. HO to make regulations re: sanitary conditions of dairy 12. Milk vendor to supply milk samples on request 13.Fines & process for convictions	
By-law 1003 May 27, 1895	2. Creates officer called Veterinary Inspector (VI) 3. Tuberculine test or any other expedient test to be used	Dairymen's Assoc. disputed right of the city to use tuberculin test Dr. J. P. Pennefather disputed efficacy of tuberculin test. Wpg Dairy Association asked for abolition of TB test Letter from J. Arnot & others asked for abolition of TB test Withdrawn July 10, 1895, By-Law 1004 substituted
By-law 1004 June 17, 1895	10. Vendor may request a sample be proved to him at same time sample for testing is taken 11. HO or VI must give notice of reasons for vendor not being in compliance 13. Failure of above to give notice shall not relieve vendor from penalties 14. HO or VI can inspect any cow in city limits, whether milk sold or not. Tuberculine test or any other expedient test may be applied. 16. Tags to be prominently displayed	Charges filed against Dr. Hinman by Dairy Association Mr. Mather appeared on behalf of the Dairymen's Assoc. at Council Mr. Taylor asked for compensation clause Mr. Barker accused Hinman of unreliable examination of cattle. Sections 1 and 3 of by-law quashed.
By-law 1176 July 10, 1896	1. HO shall keep register 2. VI shall act under direction of HO, office held at pleasure of Council 3. All vendors in city shall obtain license 6. Lawful for VI to enter premises, use tuberculine test or any other test 7. Tuberculine test may be used for cattle kept near dairy cattle 8. No licence if person does not comply re: a) diseased animals & sick dairy workers l) wash utensils n) clean delivery wagon q) sick people not to handle milk	Requests from dairy producers for refund of dairy licenses By-law quashed by Court of Queen's Bench: Council has no power to require license for those who merely deliver milk to or in the city; must restrict to vendors. Time allowed to re-inspect TB positive cattle too long. Council must issue license immediately if regulations complied with Council cannot waive regulations under special circumstances Council cannot impose both a license fee, and a further fee for each cow. City's legal counsel suggest that this judgement might make it necessary to consult the Legislature for changes in provincial laws.
By-law 1313 May 25, 1897	3. persons who sell or propose to sell milk for use in city require license 16. vendors must allow inspection, including use of tuberculine 17. licensee must say where he obtained milk he is delivering 22. vendor must give samples of milk for testing	Writ of summons from Court of Queens Bench re: motion to quash by-law Taylor vs. city: Mr. Justice Dubuc sustained the by-law Appealed late Nov./early Dec. before full court By-law sustained, except sections 17 and 18 City solicitors suggest striking out 17, providing compensation re: 22.
By-law 1352 Dec. 1897	changes clause 22, previously quashed by Court of Queen's Bench	not proceeded with

By-law/Date	Provisions Added/Refined	Response/Result
By-law 1621 May 18, 1899	9.Inspection as soon as possible after application 11. report posted in office of city clerk for 1 week 12. if no objections within 8 days, license issued 22. samples to be given on request, payment to be tendered for same 23. duplicate samples for vendor can be requested 25. HO or VI can inspect any cattle in city, tuberculin test may be used; tuberculin positive animals to be separated from herd	
By-law 1908 Feb. 1901	8 (a) amended to read "It shall not be necessary to employ the tuberculin test but the VI in his report mentioned in sections nine and ten thereof, shall state whether the same was employed	tuberculin test rarely used for dairy inspections
By-law 3852 April 3, 1905	Repealed sections 9, 12, 13, 24 of By-Law 1621 Minor word changes in 9, 12, 13, 24	
By-law 5049 February 19, 1908	Repealed 1621 and 3152 1908 clause "not necessary to use tuberculin" gone 8. No license if conditions not complied with 18. Power to inspect all places where milk is kept (restaurants, etc.) 19. Duty to inspect all places where milk is kept 36. Vendor to report sickness of self, family, employees to HO 39. Must report disease in cattle to HO	quashed by courts
By-law 5537 March 15, 1909	Repealed 1621 and 3582 2. Control & supervision of milk supply, under direction of HO, carried out by bacteriologist, city VI, and dairy inspectors (DI) 6. VI, DI can enter & inspect; use tuberculin or other test 7. Tuberculin test can be used in any cattle kept near dairy cows 8. Conditions under which license will be granted - cattle, stable, etc. a) defines positive tb test -reactors to be separated from herd 9. Inspection to occur as soon as possible after license application; 18. right to take samples from each vessel in which milk stored	
Unnumbered By-Law 1911	No new dairy licenses unless a) herds are tested and found free from TB b) barns & milk houses meet Dept. standards Cattle to be tuberculin tested as often as considered necessary by VI Diseased animals to be earmarked & removed from herd Healthy cattle to have dated ear tag & be re-tested at least yearly After June 1, 1913, dairy operators currently must comply with above After June 1, 1915, all milk offered for sale in city, whether pasteurized or not, shall be from cattle tested and found free from TB	May 16, 1911 Letter from H.H. Saunderson, representing the dairymen Not opposed to tuberculin testing if compensation provided. Conditions for TB testing set out Alternative to compulsory testing: -city to establish a central pasteurizing plant where dairymen can have their milk pasteurized at nominal cost Shelved pending sitting of the Provincial Legislature in 1911
By-law 9735 March 4, 1918	Milk vendor convicted 3 times for infractions of By-Law shall have license cancelled	city dairy inspectors now able to deal with repeat offenders

By-law/Date	Provisions Added/Refined	Response/Result
By-law 10552 May 9, 1922	4. Every cow in city, or whose milk is offered for sale in city subject to tuberculin test 8. By 1924, no sale of raw milk or cream unless from TB free herds 10. Two classes of dairies: a) raw milk, b) pasteurized milk 34. Raw milk from untested cattle to be pasteurized. 47. Milk cannot be transferred from 1 container to another during delivery unless to purchaser's container	creates tuberculosis eradication strategy for Winnipeg enables Winnipeg to participate in the Federal bovine tuberculosis eradication program theoretically eliminates *M. bovis* from the city's milk supply

Source: CWA.. All by-laws prior to 1900 are in their original form or on microfilm. The first comprehensive publication of the City's by-laws was in 1900, and included all by-laws then still in force. Each subsequent year, all by-laws passed in that calendar year were published and bound.

In October of 1894, as part of a larger initiative to reduce the spread of bovine tuberculosis in Canada, the Federal Government announced that it would supply tuberculin at the users' cost to those interested in having their cattle tested.[23] Tuberculin testing had been fraught with controversy in every jurisdiction in which it had been introduced. Dairy producers believed that it was unreliable, created a health risk for their dairy herds, and resulted in the unnecessary destruction of valuable animals.[24] Since most compensation programs paid farmers only forty to sixty percent of the value of animals destroyed, a significant portion of the cost of tuberculosis eradication programs was borne by the producer. On the other hand, local citizens and governments feared that compensation programs could be exploited by unscrupulous dairy operators who, it was alleged, would even introduce a diseased animal into their herd in the hopes of securing

[23]The current spelling of this word is 'tuberculin'. In the late nineteenth and early twentieth century, it was more commonly spelled 'tuberculine'. For purposes of consistency, unless the word is used in a direct quotation, it will be spelled "tuberculin".

[24]Church, *An Unfailing Faith*, 17, 272 n. 80.

an easy source of revenue when the disease spread to other animals.[25] Other unintended consequences of a non-universal tuberculin testing program also existed. In March of 1895, a writer to the *Manitoba Free Press* observed that some local dairymen whose cattle had been found unfit for dairy production traded them to more distant farmers for "hay or anything else convenient." The danger of this practice, observed the writer, was that "One such beast, no matter how well it looks, may become a centre of fresh infection, and the test meant to protect us be made a means to spreading the evil."[26] To avoid these problems, the federal government refused to compensate owners for the destruction of cattle that reacted to the tuberculin test.[27] This short-sighted policy created significant problems for local and provincial governments interested in establishing effective bovine tuberculosis control programs within their own jurisdictions.

Despite these shortcomings, Inglis decided to determine the prevalence of tuberculosis in cattle living within Winnipeg's city limits. He secured enough tuberculin to test 1400 head of cattle. In his letter to the Health Committee, Inglis carefully outlined his approach to the elimination of tuberculosis in dairy cattle:

> In making the general test it will be necessary to also take steps to eliminate the disease from cows owned by private citizens as well as dairy cows as they are all pastured together during the summer and as the

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[25]An article recounting the emergence of this problem in the United States was published in the local press in 1895. See: "The Tuberculosis Scare" *Manitoba Free Press*, March 6, 1895, 3.

[26]"Tuberculosis in Cows". Letter to the *Manitoba Free Press*, March 14, 1895, 4. The letter is signed 'Vigilance'.

[27]Church, *An Unfailing Faith,* 16-17; "The Tuberculosis Scare" *Manitoba Free Press*, March 6, 1895, 3.

> disease is contagious it would not be fair to dairymen to test their cows without seeing that the others also were free from tuberculosis.[28]

Inglis also raised the thorny issue of compensation for condemned animals, but made no recommendation as to what the city health department should do.

By late February, discouraging results about the prevalence of bovine tuberculosis were already available. Of two hundred animals tested, approximately thirty percent had a positive reaction. Extirpation of the disease within the city limits would require a slaughter of such magnitude that the issue of compensating owners for their losses could not be avoided. The city's Legislative Committee requested the provincial government to give the city the power to control tuberculosis in dairy cattle, and, if possible, to offer compensation to fifty percent of the value of animals destroyed under this program.[29] Legislation allowing the city to use the tuberculin test was obtained, but the provincial government did not respond to the issue of compensation.[30]

A contentious debate within the Market, License and Health Committee about whether or not to continue tuberculin testing ensued. After an impasse at the March 6th meeting, where a motion by Alderman McCreary to discontinue tuberculin testing until the provincial government took some responsibility for the eradication of tuberculous

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[28]CWA, Market, License and Health Committee Reports. Letter from M. S. Inglis to the Committee, January 29, 1895. This letter is also reproduced verbatim in the *Winnipeg Free Press*, January 31, 1895, 5.

[29]CWA, Market, License and Health Committee Minutes, February 27, 1895, Item 642.

[30]CWA, Market, License and Health Committee Reports, March 13, 1895 and April 25, 1895; Manitoba, "An Act to Amend "The Municipal Act."

animals was defeated, the committee agreed to call a general meeting of "the medical men, veterinary surgeons and all the aldermen of the Council to discuss the question with a view of considering the whole question and of obtaining further information on the subject."[31] In addition to those invited, the public meeting was also attended by "quite a large delegation of dairymen and milkmen."[32] While the committee certainly obtained further information, its task remained difficult. The discussion "revealed a direct difference of opinion [between veterinarians and private physicians] . . . as to the serious nature of the disease and its effect on the human system." The former argued, as did the two medical health officers present, that bovine tuberculosis was a significant factor in the etiology of human tuberculosis. The private physicians expressed reservations about a controlling human tuberculosis by regulating the dairy industry, stating that the tuberculin test was not reliable, and that the risk of transmission from cattle to humans was exaggerated. The meeting adjourned at 11:15 pm, no consensus having been achieved.[33]

The debate continued after the meeting. Dr. J. P. Pennefather, a private physician and unsuccessful applicant for the post of medical health officer, put his opinions about bovine tuberculosis before the public in the daily press. In a long letter to the *Manitoba*

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[31]CWA, Market, License and Health Committee Minutes, March 6, 1895, Item 643; "Tuberculosis Agitation: A General Meeting of Physicians and Veterinarians to be Called" *Manitoba Free Press,* March 7, 1895.

[32]"The Doctors Differ: A Conference on the Question of Tuberculosis Among Cattle" *Manitoba Free Press*, March 12, 1895, 5.

[33]CWA, Market, License and Health Committee Minutes, March 11, 1895, Item 644; "The Doctors Differ: A Conference on the Question of Tuberculosis Among Cattle" *Manitoba Free Press*, March 12, 1895, 5.

Free Press, he expressed his doubts about the transmission of bovine tuberculosis to humans and about the efficacy of the tuberculin test. All of these "fads", he stated, discouraged settlement in the West and aroused unwarranted fears in the minds of citizens.[34] On the other hand, Dr. Hinman, the city's Veterinary Inspector, was so determined to convince the Health Committee of the dangers posed by bovine tuberculosis that he arranged for two more veterinarians to appear at the Committee meeting of March 13, 1895.[35]

Armed with provincial legislation permitting the use of the tuberculin test, and the support of Winnipeg's veterinarians, Inglis embarked on a five year campaign to toughen Winnipeg's dairy by-laws. A by-law was drafted that empowered the city's veterinary inspector to inspect dairies and dairy cows, and to use the "tuberculine test or any other expedient test " during the inspection [Table 3-1].[36] A storm of protest erupted in response to Inglis's initiative. On May 13, 1895, city Council received a letter from the Winnipeg Dairy Association asking "that the use of Tuberculine be abolished as a test of

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[34]J.P. Pennefather, "Tuberculosis." Letter to the *Manitoba Free Press*, March 15, 1895. Pennefather originally arrived in Winnipeg in 1880. He served as a Medical Officer during the 1885 Rebellion, and returned to Winnipeg in 1886, setting up a practice in North Kildonan. In 1887, he was an unsuccessful applicant for the position of Winnipeg's medical health officer. In 1903, he moved to Holland, MB, and actively promoted Holland the site for the provincial tuberculosis sanatorium. See: CWA, Market, Licence & Health Committee Minutes for April 13, 1887; Mitchell, *Medicine in Manitoba*, 111-112; Sundell et al., *Holland Manitoba,* 39-40.

[35]CWA, Market, License and Health Committee Minutes, March 13, 1895, Item 651: "Tuberculosis Again" *Manitoba Free Press*, March 14, 1895.

[36]CWA, By-Law 1003, introduced to City Council May 27, 1895. Clauses 2 and 3 contained these proposed changes.

the fitness of cows for Dairy purposes, in this city."[37] A second letter, bearing the signatures of sixty-nine local dairymen, was read in Council May 27, 1897.[38]

In the meantime, the Health Committee had shelved the draft by-law and commenced work on a new one, which contained additional clauses with respect to regulation of the milk supply [Table 3-1].[39] On the evening that the by-law was debated by Council, the Dairymen's Association's lawyer appeared "and objected to features in almost every clause."[40] Despite his efforts, the by-law was passed with only minor changes. Clearly disappointed by this outcome, Mr. Taylor, a Winnipeg dairy producer, asked that a clause providing compensation for animals destroyed because of positive tuberculin tests be inserted into the by-law. He also, according the *Manitoba Free Press*, "accused council of taking dairymen's living out of their hands."[41]

On April 30, 1896, another dairy producer, Mr. Elliott, made application to Court

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[37]CWA, Communications to Council #3006. Letter from the Winnipeg Dairy Association, signed by Peter Arnot, Secretary Treasurer, dated May 11, 1905.

[38]CWA, Communications to Council #3020.

[39]By-Law 1004 was introduced to City Council June 10, and passed June 17, 1895. However, By-Law 1003 was not formally withdrawn until July 10, 1895.

[40]"To Secure Pure Milk: The Dairy By-Law Passed by the City Council-Objections Raised by the Dairymen-Synopsis of the Provisions," *Manitoba Free Press*, June 18, 1895, 4.

[41]"To Secure Pure Milk: The Dairy By-Law Passed by the City Council-Objections Raised by the Dairymen-Synopsis of the Provisions," *Manitoba Free Press*, June 18, 1895, 4.

of Queen's Bench to quash the new by-law.[42] Elliott questioned the city's right to inspect rural dairies, and argued that the Health Officer could not both inspect dairies and issue dairy licenses. This procedure, it was argued, eliminated an appeal process should the application for a dairy license be denied. Although these were the official points of law presented to Mr. Justice Bain, it is evident that at the heart of the legal dispute was the dairy operators' resistance to tuberculin testing. Elliott's lawyer, in his submission to the Court, stated that "numerous dairymen do not approve of the tuberculine tests and consider that they are not reliable." Mr. Justice Bain ruled in favour of the plaintiff, finding that, under the 1894 Municipal Act, the city could not inspect or license rural dairies which sold milk to others to sell in the city. He also ruled that Council could not delegate licensing authority to the Medical Health Officer.[43]

Heated debates and legal wrangling continued between 1896 and 1897 as Council introduced three more dairy by-laws [Table 3-1].[44] Two of these were successfully contested by dairy producers in Court of Queen's Bench.[45] In response to the legal

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[42]CWA, Communications to Council # 3161. The letter, from the law firm of Martin, Mathers and Anderson, was read in Council December 10, 1895. The letter is not in the existing file; Market, License and Health Committee Minutes, January 14, 1895; "Dairy Inspection By-Law: Mr. Martin Makes Application to Quash By-Law 1004." *Manitoba Free Press*, May 1, 1896, 6. At issue were clauses 1 and 3 of the By-Law.

[43]See: Patterson and Taylor, "Re: Elliot. In the Matter of By-Law 1004," 358-362; "The Dairy By-Law: Sections One and Three Quashed with Costs" *Manitoba Free Press*, May 21, 1896, 6.

[44]These were By-Law 1176, passed July 10, 1896, By-Law 1313, passed May 25, 1897, and By-Law 1352, which was introduced to Council in late 1897, but not enacted.

[45]"The City Dairies: Second By-Law to Regulate them is Quashed." *Manitoba Free Press*, January 1, 1897, 6. By-Law 1313 was initially sustained, but when appealed

judgements rendered against the city's dairy by-laws, Inglis and the city solicitors fine-tuned the regulations. Despite these refinements, the two most contentious issues, the use of the tuberculin test, and the provision of compensation for condemned animals were not resolved.[46] Certainly, no help was forthcoming from the Federal Government. In 1897, it allocated $20,000.00 for the prevention of bovine tuberculosis and undertook the cost of tuberculin testing. However, free testing was done only at the farmer's request, and the policy of not compensating owners for the loss of cattle diagnosed with tuberculosis was continued. A further disincentive to farmers contemplating participation in this program was that the Federal Government required them to sign an agreement stating that they would not use animals which tested positive, or any of their products, for food.[47]

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to the full court, Sections 17 and 22 were quashed. "The Dairy By-Law: Application to Quash Made Before Mr. Justice Dubuc." *Manitoba Free Press*, July 13, 1897, 6; "The Full Court." *Manitoba Free Press*, December 1, 1897; "The Dairy By-Law: Judgements Delivered by the Full Court." *Manitoba Free Press*, December 13, 1897.

[46]Court of Queen's Bench did not, in any of its three judgements, comment directly on the use of the tuberculin test or on the issue of compensation. Power to use the tuberculin test was no doubt accepted under the provisions of the 1894 Municipal Act. In the absence of any clear indication of what level of government was responsible for compensating farmers for the destruction of tuberculous cattle, the Court gave no direction to the city on this issue. For examples of the debates in Council about these issues, see: *Manitoba Free Press*, June 9, 1896, 5; "The City Dairy By-Law" *Manitoba Free Press*, July 11, 1896, 8; "A Long Session" *Manitoba Free Press*, May 26, 1897.

[47]Church, *An Unfailing Faith,* 16-17; "The Tuberculosis Scare" *Manitoba Free Press*, March 6, 1895, 17. A letter from Hon. Sidney Fisher, Federal Minister of Agriculture, to M.S. Inglis, dated October 19, 1898, stated that the Federal Government authorized Dr. Charles Little, V.S. to do tuberculin testing for the city at the Federal Government's expense. However, the Federal Government only required that the animals be quarantined. See: Communications to Council, #3953. The *Manitoba Free Press* carried a reminder to readers of this policy in 1899. See: "A Misapprehension: Dominion Government has No Liability in Connection with Tuberculine Tests" *Manitoba Free Press*, March 15, 1899, 6.

Winnipeg's dairy producers continued to exert pressure on city Council and its health officials by applying for the refund of dairy license fees collected under the quashed by-laws. In at least two instances, legal action was threatened if the fees were not refunded with interest.[48] Public pressure was also brought to bear on Council's regulation of the city's milk supply. A large public meeting was convened on March 11, 1899. William Hespeler, the elected chair "announced that the meeting was open to any gentleman who might wish to express his opinion on the subject the meeting was called to consider."[49] The fact that efforts to create a pure civic milk supply were exclusively led by male bureaucrats and health officials was not lost on at least one member of the audience. Mr. Taylor, Secretary of the Dairymen's Association, observed that "the ladies of the city were quite satisfied with the milk they were getting and therefore there were none of them present in the meeting."[50] After the usual debates about the efficacy of tuberculin testing and the need to compensate dairy farmers for cattle slaughtered after testing positive for tuberculosis, the meeting "almost unanimously" passed a motion urging Council "to take all necessary steps to secure the purity of milk and meat & that

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[48]CWA, Communications to Council, # 3392 letter from Martin, Mathers & Anderson on behalf of several dairymen dated August 15, 1896; #3508 letter from Lendrum McMeans, Barrister on behalf of Mr. S. W. Mawson dated February 22, 1897; letter from Elliot & McCreary on behalf of Mr. Elliot, dated March 27, 1897. The issue of whether or not to refund dairy license fees was discussed frequently by the Market, License and Health Committee during 1897. See, for example, the minutes of January 12, February 25, April 6, May 4, and May 18, 1897.

[49] "Questions of Milk Supply: Citizens Discuss the Matter in the City Hall on Saturday" *Manitoba Free Press*, March 13, 1899, 3.

[50] "Questions of Milk Supply: Citizens Discuss the Matter in the City Hall on Saturday" *Manitoba Free Press*, March 13, 1899, 3.

the principle of compensation be introduced into this matter."[51]

In response to this public outcry, yet another dairy by-law was passed by Council on May 18, 1899. However, it did little more than confirm the existing powers of city health authorities and the rights of dairy producers. Tuberculin testing was, in fact, almost a dead letter because veterinary inspectors would only conduct the test on the request of the dairy operator. While the city's pre-1900 dairy by-laws did go some distance towards improving the hygienic standards of "those dirty dairies," the capacity to prevent the spread of tuberculosis amongst dairy cattle and to prevent the spread of milk borne diseases within the city limits continued to elude health officials.

Between 1894 and 1900, Winnipeg's health officials relied almost exclusively on regulatory strategies to clean up the city's milk supply. Their efforts, however, met with limited success. Although dairy inspectors could insist that dairies meet minimum hygienic standards prior to being issued a license, no real headway was made on the more difficult issue of ensuring that tuberculosis was eliminated from the milk supply. The senior levels of government continued to favour voluntary tuberculin testing, and refused to tackle the thorny issue of compensation for animals destroyed under these programs. Faced with the seemingly insurmountable obstacles of political neglect and dairy producer resistance, the city health department had virtually suspended tuberculin testing by 1900. Early efforts to clean up Winnipeg's milk supply had ended in a stalemate.

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[51] "Questions of Milk Supply: Citizens Discuss the Matter in the City Hall on Saturday" *Manitoba Free Press*, March 13, 1899, 3; CWA, Communications to Council, #4049 from G. A. Greathed, secretary of public meeting dated March 13, 1899.

New Initiatives to Clean up the Milk Supply, 1900 - 1913

Between 1900 and 1913, Winnipeg's public health officials embarked on a different set of tactics to clean up the civic milk supply. Regulatory strategies continued to hold centre stage during this era, and new regulations were introduced to refine and extend those already enacted. However, the health department also attempted to draw women into the fray as allies to their cause. The pressure that the well-educated consumer could exert on milk producers, it was hoped, would turn the tide in the health department's favour. As well, the department committed significant resources to assist milk producers. Educational programs, intended to convince "dairymen" of the benefits of operating a hygienic dairy, were offered. Material assistance was also proved to those willing to construct modern dairy barns and milk houses.

The establishment and maintenance of a safe urban milk supply had become a cornerstone of communicable disease control at the turn of the 20th century. A fairly similar pattern of increasingly stringent regulations regarding the production and marketing of milk evolved in most major North American and European cities. Sanitary guidelines set out proper procedures for care of the dairy herds and barns, the location of wells, and the proper handling of the milk at the point of production. Guidelines for the health of individuals in contact with the cattle and milk were also developed. These evolved into regulations requiring milk and cream producers to purchase permits to sell milk. Dairy score cards were introduced in the United States in the first decade of the twentieth century to facilitate the regulation of the milk supply. By 1911, 94% of major American cities surveyed required permits to sell milk and cream within their

jurisdictions and 63% used score cards to rate individual dairy farms on a variety of parameters. Producers and vendors not complying with civic dairy by-laws could have their permits revoked.[52]

Increasingly stringent bacteriological regulations governing the quality of the milk were also enacted. However, mandatory pasteurization of milk was still controversial. Wholehearted endorsement of this public health measure was slow to develop, but by 1914, Douglas reported that: "As usual, I found the (American Public Health) Association almost unanimous in recommending pasteurization as the most efficacious means of rendering milk safe under present conditions of production."[53]

The Winnipeg health department's efforts to create a safe civic milk supply followed a similar pattern. The 1904 typhoid epidemic gave Douglas the public and political support necessary to expand the dairy inspection program inherited from Inglis. The suspicion that at least some of the typhoid cases had contracted the disease from milk delivered along specific delivery routes enabled health officials to extend their regulatory strategies from milk producers to milk vendors, particularly those who delivered raw milk directly to the consumer.[54]

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[52]Thomas, "A Review of Practical Methods," 800.

[53]CWA, Health Committee Communications, Box 716, File 1185. Letter from Douglas dated December 17, 1914 entitled "Report of the 1914 meeting of the American Public Health Association." See also: Strauss, "Saving Children from Milk-Borne Diseases," 109-110. Strauss states that the pasteurization of milk is the single measure most likely to save the lives of infants.

[54]CWA, Communications to the Health Committee, March 7, 1905, Item 116; Jordon, "Report on Typhoid Fever in Winnipeg," 184-186. Professor Jordan, in his 1905 report to City Council, stated that contaminated milk along at least two milk routes could

The department's dairy reports in the years prior to and immediately after the 1904 typhoid outbreak reveal that the dairy inspectors had retreated from the aggressive approach used by Dr. Dunbar in the late 1890s. Dunbar had used the tuberculin test regularly, and often ordered dairy operators to remove diseased animals from their herds.[55] In contrast, monthly dairy reports from J. S. Roberts, Dunbar's successor and the city's first dairy inspector, do not reveal much evidence of sanitary problems or threats to public health at Winnipeg's dairies. No tuberculin testing was documented, dairy premises were routinely reported as satisfactory, and the majority of cattle inspected were apparently clean and healthy. This simply could not have been the case. A letter written by A. Harvey to City Council in 1900 complained about "one of the worst (dairy) yards I have seen yet." Harvey characterised the dairy as a "muck hole" capable of spreading typhoid fever to nearby hotels. "The health inspector" he wrote, "was aware of all this, but there is too much favoritism shown."[56] L. A. Gibson, the Chief Dairy Inspector,

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not be ruled out as a source of infection for 20 cases of typhoid, and that 6 more cases, scattered amongst three other milk routes were highly suspicious. In his recommendations, Jordan stated that "Inspection of the sources and routes of milk supply cannot be too vigilant at times when typhoid fever is known to prevail." This was the first time, at least in Winnipeg, where milk delivery rather than its production was implicated as the source of a typhoid outbreak. In response to the Jordan Report, and Mayor Thomas Sharpe's report on his tour of the sanitation systems in Eastern Canada, Council instructed Douglas to conduct more stringent inspections of the city's dairies, and to hire more help, if necessary.

[55]CWA, Health & Relief Reports, 1874-1891. In the back of this box are a number of applications for a dairy license dated 1894 and 1895. They are so fragile that it was not possible to conduct a thorough examination of each application. In 1898, it appears that all cattle examined by Dunbar were tuberculin tested.

[56]CWA, Communications to Council #6210. Letter from A. Harvey dated October 6, 1900.

confirmed that Winnipeg's dairies fell far short of ideal sanitary conditions: "We find a few very good dairies. But the most of them are only in fair condition. We must keep continually after them to keep stables and milk houses clean."[57] The following month, Gibson reported that four dairies had been closed "on account of their being in a bad condition."[58]

Between 1908 and 1913, the health department introduced five new initiatives to refine their existing regulations [Table 3-2]. The introduction of dairy score cards, the compulsory reporting and follow up of sickness at dairies, the clean-up of milk wagons, the establishment of a Milk Commission, and the enforcement of provincial regulations controlling the adulteration of milk enhanced the department's capacity to standardize dairy inspection, and to contain or prevent outbreaks of milk borne diseases.[59]

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[57]CWA, Health Committee Communications, Item 1094. Letter from L.A. Gibson to A.J. Douglas dated September 1908.

[58]CWA, Health Committee Communications, Item 1131. Letter from L.A. Gibson to A.J. Douglas dated October 29, 1908.

[59]For Douglas's report of the use of dairy score cards in the United States, see; CWA, Communications to the Market, License and Health Committee #867, dated October 30, 1907. The introduction of the cards by Winnipeg's dairy inspectors is discussed in the Health Department *Annual Report* (1908): 28. Discussions re: the mandatory reporting of sickness on dairies can be found in the Health Department, *Annual Report* (1908): 26, and the *Annual Report* (1911): 138. The clean-up of milk wagons is discussed in the Health Committee Communications, Item #82, Dairy Inspection Report for April 1909, submitted by L. A. Gibson to A. J. Douglas. Initial reports of the founding of the Winnipeg Milk Commission are found in the *Annual Report* (1909) 23, and the *Annual Report* (1910) 27. Discussion of the health department's decision to enforce Section 89 of the Provincial Health Act is found in the Health Committee Minutes of December 11, 1911, Item 578.

Compulsory certification improved the expertise of the department's dairy inspectors.[60] Two investigations kept the issue of bovine tuberculosis and pasteurization before the Health Committee during an era when both measures continued to be fraught with controversy.[61] These efforts were greatly enhanced by the appointment, in 1910, of P. B. Tustin as head of the newly re-organized Food and Dairy Division.[62] Tustin brought to this position a level of energy, expertise, and passion which had been notably absent during the tenures of earlier dairy inspectors.

Table 3-2 Regulatory Strategies, Other than Dairy By-Laws: 1900 - 1913

Initiative	Date	Intent	Outcome
Dairy score cards	1908	-standardize dairy inspections -provide baseline for minimum standard -keep dairy operators & consumers informed	- improvement in dairy scores -closure of some dairies - % of dairies scoring "good' increased from 25% to 50% -unable withhold license if score below minimum standard -more difficult for small dairy operator to comply
Compulsory reporting of sickness at dairies	1908	-eliminate bacterial contamination of milk	-better containment & prevention of some outbreaks of milk borne diseases
	1911	-Communicable Disease Division follows up on reported illnesses	-more expertise to deal with human illness

[60]CWA, Health Department, *Annual Report* (1912) 16.

[61]CWA, Health Committee Communications, 1911, #449/453/477/495/496; Health Committee Minutes, December 26, 1913, Item 964.

[62]CWA, Health Committee Communications. Letter to J. F. Pearson, Chief Inspector, from Percy Brook Tustan. The letter is referred to in Item 638 of the Health Committee Minutes. Tustin was first hired by the city health department in 1907 as a meat inspector. His letter of application, dated February 14, 1907, gave evidence of considerable experience with livestock as a cattle foreman, inspector, and veterinary assistant in Britain, South Africa, Argentina and the United States.

Initiative	Date	Intent	Outcome
Clean-up of milk delivery wagons	1909	-reduce contamination of milk during delivery	
Establishment of Milk Commission	1910	-create a supply of certified raw milk to satisfy those opposed to pasteurization	-poor participation because tuberculin testing mandatory -other regulations imposed -milk more expensive
Health Committee investigation of complaint of William Roberts	1911	-mobilized city authorities to recommend pasteurization of all milk from non-TB tested cattle	-2 by-laws to accomplish same (1911, 1913) not enacted -accusation that city putting small operators out of business
Enforcement of Provincial health Act, section 89 defining milk	1911	-prevent adulteration of milk	-better & more systematic labelling of milk delivered to consumers
Certification of all Dairy Inspectors	1912	-improve qualifications and knowledge base of inspectors	
Committee to investigate establishment of a segregated area for Winnipeg Dairies	1913	-reduce transmission of TB in cattle herds	-no further report

Sources: CWA, Health Department *Annual Reports*, 1908-1913; Health Committee Minutes, December 11, 1911; Communications to the Health Committee #449/453/477/495/496, April-June, 1911.

Small milk producers were a particular challenge to the health department. These entrepreneurs typically entered the retail market only when the few head of cattle they owned were producing more milk than their own family could consume, or when the price of milk was sufficiently high to make the effort of milk production worthwhile. The barns, milk houses, cattle, and delivery wagons of "this class" of dairy producer were often described as dirty and substandard. Because revenues from the sale of milk only supplemented other sources of income, small producers were less inclined to adhere to the sanitary standards of the health department. To ensure that they did, the dairy inspectors allocated a disproportionate amount of time to the inspection of these premises. Small dairy farms in West Kildonan were singled out as a major problem.

> North of the city, in the Municipality of North Kildonan, a large number of dairies are congregated so close together that in about a square mile of territory we find 37 licensed dairy barns, 23 barns occupied by milk shippers and several smaller stables utilized as cow sheds, piggeries, slaughter houses, etc. This condition is due to a spontaneous evolution of what might be called a "community system." The proprietors of these dairies in many cases own very little land, perhaps merely a couple of 25-foot lots . . . The manure from these stables is generally deposited on the adjacent lot, . . . and to such a degree has this practice developed that the dairies have become a source of nuisance to the residents, to each other, and to themselves.[63]

A situation like this, Tustin had observed in an earlier annual report, "would not last 24 hours within the city limits, but we have no jurisdiction outside, and can only regulate the actual premises of each dairyman."[64]

The health department sometimes cast the small dairy operator or vendor as an outsider whose primary motivation was exploitation of the consumer for his own economic gain. Only unceasing vigilance on the part of the department's employees, it was asserted in the health department's *Annual Reports*, stood between the public and the careless attitudes of uneducated foreigners. "Owing to the numbers of foreigners supplying milk to the City, our work is rendered more difficult as many of them do not understand the fundamental principles of cleanliness."[65] Jewish dairy operators experienced the most intense scrutiny, both because of their concentration in West Kildonan, and because of their alleged lack of adherence to sanitary regulations when delivering milk in the city. "Our campaign against old and dirty milk wagons is beginning

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[63]CWA, Health Department, *Annual Report* (1916), 90.

[64]CWA, Health Department, *Annual Report* (1913), 129.

[65]CWA, Health Department *Annual Report* (1909), 68.

to bear fruit, a large number of new wagons having been put on this Spring and a number of old ones painted inside and out." reported L. A. Gibson in 1909. "There are still a few however, principally among the Jews, which require attention."[66]

The legal battles during Inglis's tenure had apparently convinced both civic politicians and health officials that a pure milk supply could not be attained through regulatory strategies alone. Therefore, between 1900 and 1913, the health department introduced producer education programs to supplement and improve the effectiveness of its dairy by-laws [Table 3-3].[67] For all that the health department decried the ignorance of some dairy producers, it preferred to help them improve their practices rather than put them out of business. "With these factors before us [the lack of knowledge of some dairy producers] we have endeavored to educate the dairymen, and have only entered into prosecutions where we found he would not live up to the instructions given him and his knowledge to do what is right."[68] The improvement of sanitary conditions on the farm, which depended upon both educational and regulatory strategies, was also priorized because health authorities believed that this was the most fundamental strategy in the

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[66]CWA, Health Committee Communications, Item #82, Dairy Inspection Report for April 1909, submitted by L.A. Gibson to A.J. Douglas.

[67]CWA. The *Bulletin* was first published in August, 1911. See: Health Committee Minutes of August 11, 1911, Item 527. Regular articles on Winnipeg's milk supply and on the safe handling of milk in the home appeared in the *Bulletin* and were often re-printed in the city's newspapers. Dairy scores were also published in the *Bulletin* and in the *Winnipeg Post*. See: Health Department, *Annual Report* (1911), 122. Educational programs for milk producers were reported in the 1910, 1911 and 1912 Annual Reports on pages 98, 27, and 105 respectively.

[68]CWA, Health Department, *Annual Report* (1909), 68.

elimination of bovine tuberculosis. As Tustin explained, it was counter productive to house tuberculosis-free cattle in unsanitary barns where they would almost inevitably contract the disease.[69]

Table 3-3: Milk Producer and Consumer Educational Strategies, 1908-1914

Initiative	Year	Intent	Outcome
Publication of Monthly *Health Bulletin*	1911	-provide public with information on safe milk and other public health problems	
Posting dairy inspection results at Health Office Publish dairy inspection results in *Bulletin* & local newspapers	1908 1911	-people would patronize dairy operators with higher standards even if price higher	-worked if milk was still relatively cheap and a sufficient supply available
Producer Education programs	1910	-ensure that dairy operators understood regulations	-better sanitary conditions reported on many dairies
Consumer education programs	1911	-provide information about safe milk storage in the home	
Publication of articles in trade journals	1911	-communicate with dairy producers	
Participation in Annual Meetings, Fairs, etc.	1911	-communicate with dairy producers	

Sources: CWA, Department of Health, *Annual Report*, 1908-1914.

To improve the impact of dairy producer education programs, the city also offered material assistance to dairy operators interested in improving the sanitary conditions of their dairy barns and milk houses. Beginning in 1910, gravel and cement was provided at cost to any dairy producer, whether operating inside or outside the city limits, who

[69]CWA, Health Department, *Annual Report* (1910), 105.

wanted to improve his buildings.[70] Blueprints of barns and milk houses "suitable to his requirements " were also made available to producers planning to replace existing structures.[71] As well, the city's dairy inspectors provided on-site supervision of the construction to ensure that the finished building conformed to city regulations.[72] This program resulted in a flurry of construction on many dairy farms, and a resulting improvement in the overall dairy scores reported between 1910 and 1913.

It was also during this era that the health department embarked on a campaign to harness the power of the milk consumer to its existing regulatory and producer education programs. The primary target of consumer education programs was the city housewife, the individual most likely to make decisions about the source of the family's milk supply. This program was mounted with two goals in mind. First, health officials hoped that well-informed consumers would demand higher standards from the dairy operator who delivered milk to their home. To ensure the women could make an informed decision about which "dairyman" to patronise, the scores of each dairy inspected by the department were published in *The Bulletin*. These reports were often reproduced in the city's daily newspapers. Health officials also encouraged milk consumers to personally inspect the city's dairies. Thus, in 1911, the Department's monthly publication, *The Bulletin*, offered this advice to the women of the city:

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[70]CWA, Health Department, *Annual Report* (1910), 98.

[71]CWA, Health Department, *Annual Report* (1910), 98.

[72]CWA, Health Department, *Annual Report* (1910), 98.

> We need the support of the general public, and they can help in the following way: Ask your dairyman to show you a copy of his last score card . . . and patronize those men who score high. If he will not show you his score card, phone Garry 1010 between 9 a.m. and 10 a.m. . . . and you will be given his score. Also take an occasional trip out to the dairy that supplies your milk, if this is done, it will encourage these dairymen to keep things clean and up to date, and the outing will do you good.[73]

Although it is not known how often milk consumers actually visited the local dairies, two middle class women, "Mrs. Doctor" Hughes and Miss Grieveson accompanied the thirty-two male physicians, city health officials, dairymen, and creamery representatives who toured a model dairy, Kinalmeaky Dairy, on July 17, 1913.[74] Reform of the dairy industry and the creation of a safe milk supply had caught the attention of some female social reformers.

Second, educational programs sought to ensure that pure milk brought to the consumer's door would not become a source of illness once stored in the home. Regular articles about the safe storage of milk, particularly during the summer months, also appeared in *The Bulletin*. The co-sponsorship of All People's Mission at one public education program regarding the care of milk in the home highlights health officials' concerns about the "ignorance" of Winnipeg's eastern European immigrants. Another education series for consumers was held at the Grand Opera House in 1911.[75]

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[73]"Report of the Royal Commission on Tuberculosis," 4.

[74]Kinalmeaky Farm was located in Headingly, a small community west of Winnipeg. It was owned by F. E. Kenatson of Minneapolis, MN. A photograph commemorating the tour of July 17, 1913 is located in photographic collection of the Archives of Manitoba. Events, 343, N5005.

[75]CWA, Health Department, *Annual Report* (1911), 111. The March 13, 1913 issue of the *Bulletin* carried an article entitled "Care of Milk in the Home." The May 13,

It was soon apparent, however, that some of Winnipeg's female consumers did not support the public health measures adopted or advocated by health officials. Ada Muir, a regular columnist for *The Voice*, Winnipeg's labour newspaper, opposed both tuberculin testing of dairy cattle and the pasteurization of milk. In her commentary about the ill-fated 1911 dairy by-law, which would have made pasteurization mandatory for milk produced by untested cattle, Muir had this to say:

> This explains why so many dairymen are preparing to dispose of their stock during the present year. They refuse to have their cows diseased by tuberculine, they are not in a position to comply with extravagant building by-laws and they will not be coerced into selling their milk to the pasteurizing firms. Unless the people wake up and demand a change, it will be impossible for any resident who does not own a cow to obtain pure unfaked milk.[76]

Given Muir's general distrust of medical science, and her belief that the city's creameries were reaping significant profits on the backs of working people, her opposition to the 1911 by-law is not surprising. However, members of the middle class were also concerned that the city's dairy policies might be forcing the price of milk out of the reach of many families. In 1913, Theo Hunt, the City Solicitor, expressed these sentiments. Fearing that the Health Committee's proposal to draft legislation preventing the sale of raw milk in Winnipeg would be unpopular and, perhaps, ill-advised, he wrote:

> [I]t seems to me that in view of the agitation in connection with the high price of milk, it would be unwise to try to prevent the sale of raw milk

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1913 issue provided information about the care of milk during warm weather.

[76]Ada Muir, "Women's Column," *The Voice*, July 12, 1912, 3. The opposition of working class women and the labour press to more stringent dairy regulations also occurred in other cities. See, for example: Koslow, "Eden's Underbelly," 41-55; Leavitt, *The Healthiest City,* 161.

> within the city limits. While all these things are commendable, the ultra refinements are costing the consumer a lot of money.[77]

In the health department's 1913 *Annual Report*, both Douglas and Tustin expressed confidence that their three-fold strategy of regulation, education and material assistance had borne fruit. A more rigorous approach to inspection and enforcement had convinced most dairy operators that the city was serious about creating a pure milk supply for its citizens. There were more large dairy producers, and the "small dairy man and milk peddler" had become more rare.[78] In the opinion of health officials, this development signalled that more producers were committed to the industry over the long term and were willing to invest the time, money, and energy necessary to sustain their operations. Sending city dairy inspectors up to one hundred miles outside the city twice a year to inspect large dairy operations was a significant strain on the department's resources, but one which its key officers never questioned.[79]

Tuberculin testing was still voluntary, and no compensation was yet available for dairy producers forced to slaughter tuberculin-positive cattle. However, health officials noted that more dairy producers seemed convinced that the higher consumer price obtained for tuberculosis free milk more than compensated for the short term economic loss which accompanied the elimination of tuberculous animals. Between 1911 and 1912,

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[77]CWA, Communications to Health Committee #952/962/1034/1053/1063/1223; Correspondence from Theo A. Hunt to the Health Committee, December 5, 1913.

[78]CWA, Health Department, *Annual Report* (1912), 20.

[79]See, for example, CWA, Health Department *Annual Report* (1912), 130. What Tustin requested repeatedly was the allocation of a car for rural inspections. The horses, he complained, wore out during the rigours of the twice a year inspection program.

the number of dairy herds believed to be tuberculosis free rose from three to twelve, and an increasing number dairy operators asked to have their herds tested.[80]

The optimism about the effectiveness of Winnipeg's dairy policies was also derived from a general decrease in the tuberculosis mortality rates [Figure 3-1] and the incidence of other milk borne infections, particularly between 1910 and 1913. Only three outbreaks of typhoid fever had been linked to the milk supply. This included two outbreaks in 1908 involving a total of 38 cases and one outbreak in 1912 involving 92 cases.[81] Despite continuing controversies, the supply of pasteurized milk had increased from twelve percent of the total milk consumed in the city in 1908 to sixty-seven percent in 1913. "It looks" reported A. J. Douglas in 1913, "as though the supply of raw milk from untested herds will gradually eliminate itself without the aid of special legislation to that effect."[82]

Despite these positive developments, two major challenges to the creation and maintenance of a pure milk supply remained unresolved. The first was the issue of compensation to dairy farmers for animals slaughtered to eradicate *M. bovis* from their herds. City Council correctly believed that they had neither the jurisdictional authority nor the fiscal resources to offer compensation to dairy producers, particularly those who operated outside of the city limits. However, there was confusion about which more

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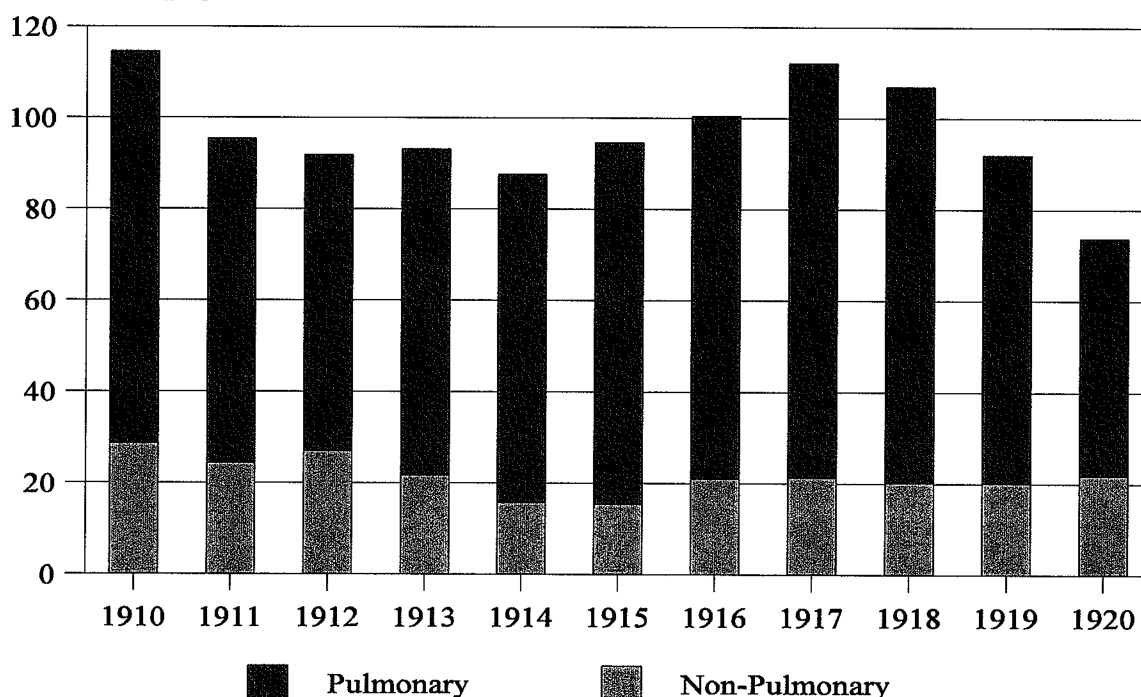
[80]CWA, Health Department, *Annual Report* (1911), 28; *Annual Report* (1912), 8, 117.

[81]CWA, Health Department, *Annual Report* (1908), 4; Health Department, *Annual Report* (1912), 9.

[82]CWA, Health Department, *Annual Report* (1913), 127.

senior level of government should finance a compensation program. This allowed both the federal and provincial governments to duck the issue and leave city governments, dairy producers, and consumers holding the bag.

Figure 3-1: Pulmonary & Non-Pulmonary Tuberculosis Mortality Rates/100,000 Pop.: Winnipeg 1910-1920



Source: CWA, Health Department, *Annual Reports*, 1910-1920.

The second unresolved problem was the city's failure to obtain the power to regulate the pasteurization of Winnipeg's milk supply. By-laws requiring that milk sold within the city limits be either pasteurized or obtained from tuberculosis free herds were developed in 1911 and 1913. However, both were shelved because the provincial

government would not pass the necessary enabling legislation.[83] These deficiencies in the city's dairy regulations, the onset of the First World War, and ten winters of milk famines all contributed to a general decline in the quality of the milk supply between 1914 and 1922.

In summary, between 1900 and 1913, the health department's strategies to create a safe civic milk supply shifted from regulatory strategies alone to incorporate educational programs and material support for dairy farmers. In addition, women were encouraged to participate in the debates concerning the department's dairy policies for the first time. However, the participation expected of them by the city's health officials was confined to exerting public pressure on dairy producer and politicians. In reality, women's opinions on the issue were as divided as those held by men, and they did not form a solid block in support of the city's dairy regulations.

Crisis and Compromise: Dairy Policies between 1914 and 1922

Between 1914 and 1922, sweeping social and political changes had a profound impact on the Health department's dairy policies. While a supply of safe milk had been the primary preoccupation of the previous era, the most pressing issues during and immediately after the First World War were its price and availability. Milk was now accepted as a staple in a healthy diet, especially for children. During the economic crisis of the First World War, milk prices rose to unprecedented levels. At times it could not be obtained at any price. The fragile coalition of dairy producers, health officials, consumers,

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[83]CWA, Health Department *Annual Report* (1911), 33; Health Department, *Annual Report* (1913), 18.

and social reformers splintered, pitting the working class against creamery owners and health officials. Even within the middle class, opposition to the city's dairy policies emerged. Suburban housewives who followed medical advice not to feed infants and children pasteurized milk spoke out in opposition to those advocating the universal pasteurization of the city's milk supply. Finally, rural dairy producers mounted opposition against federal price controls, which held the price of milk below the cost of production, and against health officials, whose policies threatened to put them out of business.

In 1914, the health department experienced two major reversals in its campaign to clean up the city's milk supply. The first was the Federal Government's decision that Winnipeg was not eligible to participate in its new *M. bovis* eradication program which, for the first time, offered dairy producers partial compensation for animals destroyed or culled from their herds.[84] Douglas had been eager to have Winnipeg participate in this program. In a letter to the Health Committee dated July 22, 1914, he stated: "This is a very important act. . . . I should like to see the City of Winnipeg enter into the necessary agreement to put these regulations in force as I feel that they are sound in principle and should not be very difficult to apply."[85]

Unfortunately, the Federal program required participating local governments to license all dairies selling milk or cream within their city limits. Licensed dairies had to conform to federal guidelines, which included dairy barns with larger windows and more

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[84]Church, *An Unfailing Faith,* 47.

[85]CWA, Health Committee Communications #1086/1100/1115/1197, A. J. Douglas to the Health Committee, July 22, 1914.

total air space than were typically constructed by western Canadian dairy producers.[86] Winnipeg did not license rural dairies that shipped directly to the city's pasteurizing plants, and many of the dairies that they did license could not meet these new and "rather drastic" federal regulations.[87] "To do this," stated Douglas, "would necessitate a greatly increased staff of inspectors and a vast amount of work would have to be done to the premises of farmers and others supplying milk to the creameries . . . to comply with the requirements expected from licensed dairymen."[88] Doubtless, Douglas realised that most dairy producers would be unable or unwilling to embark on the major capital investments necessary to conform to the new dairy regulations during a significant downturn in the prairie agricultural economy.[89] Although Douglas appealed the Federal Veterinary-General's decision, his bid for a more lenient interpretation of the guidelines failed.[90] Winnipeg continued its campaign to combat bovine tuberculosis through its certified milk program and a voluntary tuberculin testing program with no compensation available for farmers who agreed to have their herds tested.

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[86]The federal regulations were so stringent that, by 1918, only North Battleford, Saskatoon, Regina, and Ottawa had managed to qualify for the program. See: Church, *An Unfailing Faith,* 53.

[87]CWA, Health Department, *Annual Report* (1916), 18; Health Committee Minutes of September 17, 1914, Item 1115.

[88]CWA, Health Committee Communications #1086/1100/1115/1197, letter from A.J. Douglas to the Committee dated September 16, 1914.

[89]Church, *An Unfailing Faith,* 47. For a discussion of the impact of the First World War on the western agricultural economy, see: Thompson, *The Harvests of War.*

[90]CWA, Health Committee Communications, #1086/1100/1115/1197, letter from F. Torrance, Veterinary Director General to A.J. Douglas, dated December 17, 1914.

Just prior to the federal decision, a disturbing local development cast doubt upon the effectiveness of Winnipeg's certified milk program. In November 1914, Joseph Carter lodged an official complaint against the Health department and its veterinarian, Dr. Bowman.[91] Bowman had conducted his "annual" tuberculin test on Carter's 34-head dairy herd in June, 1914. Twenty-four animals, comprising 71% of the herd, reacted to the test.[92] Based on these alarming findings, P. B. Tustin, the city's chief dairy inspector, notified the company marketing Carter's milk that it could no longer be certified as the product of a tuberculosis free herd.[93] Knowing that these results could spell the end of his certified milk business, Carter hired two private veterinarians to verify that either contaminated tuberculin or the technique Bowman had employed in tuberculin testing his cattle was responsible for the large swellings on his animals. The two veterinarians conducted their own tests and, while agreeing that Carter's explanation might plausibly explain swellings on the animals ranging in size from an orange to a grapefruit, they also

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[91]CWA, Health Committee Communications, #1154, letter from Edward Carter, Joseph Carter's legal counsel, to the Board of Control.

[92]Since Carter was a producer of certified milk, his herd should have been tuberculin tested at least twice a year, and individual animals could be tested whenever the veterinarian deemed it necessary. See: Rules and Regulations of the Winnipeg Milk Commission as Adopted October 1910, p. 6. This document was included with other papers related to the Board of Control Investigation of Carter's complaint. CWA, Health Committee Communications #1154/1184/1201.

[93]CWA, Health Committee Communications #1154/1184/1201. Report of the Sub/Committee appointed to investigate the charges made by Edward Carter in respect to test of Cows for Tuberculosis, dated December 23, 1914.

reported that at least 50% of the animals tested by them were tuberculin positive.[94]

In his report to the sub-committee struck to investigate Carter's charges, Tustin stated that Carter's dairy had conformed to the city's dairy regulations until he was given a contract to provide the Carson Dairy Co. with certified milk. After that, Tustin wrote, standards at the dairy fell and the premises were often dirty. "I went out with the Milk Commission and inspected the dairy at 11 a.m. one morning. The stable had not been cleaned, the cattle were dirty, and the [Winnipeg Milk] Commission refused to have anything to do with them." However, the case against Carter was much more serious than simply the unhygienic state of his dairy. Health officials had evidence that Carter was keeping tuberculin positive animals in his herd by removing their ear tags and replacing them with tags indicating that the animal was healthy.[95] In their report to the Health Committee, the subcommittee stated: "We have reason to believe that earmarks were obliterated from diseased animals by clipping away a portion of the ear. Tags which are numbered and indicate a healthy animal were found in the ears of animals which did not tally with the description of animals in which they had originally been placed by the

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[94]Rombough and McGillivray tested 23 animals and found 8 healthy, 3 doubtful and 11 tuberculin positive. They submitted a detailed report of their findings, including temperature charts on all tested animals, to the investigation committee.

[95]The usual procedure in a tuberculin testing program was to place an tag with the letter 'T" on it in the left ear of all animals which reacted to the tuberculin test. Animals which had not reacted to the test had a numbered and dated tag placed in their right ear. The number assigned to each animal was unique and was matched with a physical description entered in a log book kept by the veterinarian.

veterinary inspector."[96] The charges against Bowman and Tustin were dismissed.

Whatever brave face the city's health officials may have put on this sordid affair, they could not evade the conclusion that as long as raw milk was marketed in the city, milk consumers were at the mercy of any unscrupulous dairy producer who put profit ahead of public safety. The Carter scandal provided city officials with conclusive evidence that their voluntary, non-compensatory tuberculosis eradication program was doomed to failure. These events, however, were simply the prelude to four very difficult and frustrating years in the health department's campaign to create a pure civic milk supply. Three other complex and interrelated developments contributed to the decline in the quality of the city's milk supply: a decade of winter milk famines (1912 - 1922), the inflation of milk prices immediately prior to and during the First World War, and the economic crisis in the dairy industry during the same period.

The years immediately prior to and during the First World War were exceedingly difficult for Manitoba's dairy producers. The economic boom that had accompanied the expansion of agricultural production on the prairies ended in 1912.[97] The depressed wheat prices which marked the economic downturn of 1913 were not an immediate problem for dairy producers, who could now obtain feed, hay, and other necessities at a lower cost. The crisis in the dairy industry emerged when wheat prices rose during the First World

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[96]CWA, Health Committee Communications #1154/1184/1201. Report of the Sub/Committee appointed to investigate the charges made by Edward Carter in respect to test of Cows for Tuberculosis, dated December 23, 1914. See also, in this file, a letter from P. B. Tustin providing essentially the same information dated November 30, 1914.

[97]Bellan, "The Development of Winnipeg as a Metropolitan Centre," 178-251; Morton, *Manitoba: A History*, 329-330; Thompson, *The Harvests of War*, 12, 45-46.

War. The high price that wheat commanded in the market place encouraged many prairie farmers to focus exclusively on its production. No doubt many rural farmers were convinced that the additional labour necessary to maintain a dairy herd was not worth the effort.[98] However, large dairy operators who had invested significant capital in the construction of dairy barns and milk houses, and in the establishment of a high quality dairy herd were not in a position to make a similar decision. In addition, they were consumers as well as producers of agricultural products because they often purchased feed, hay, and other commodities to maintain their dairy herds. During the last two years of the war, the price of oats, bran, hay, and replacement cattle nearly doubled, as had the cost of producing milk.[99] However, income from the sale of milk had not kept pace. Each cow, reported Charles Tully, a milk producer from Raeburn, generated $150 of income per year, and cost $225 to maintain.[100]

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[98]Thompson, *The Harvests of War*, 46.

[99]AM, Animal Industry Branch. RG1 E3 1917-1965. The collection consists of a series of scrapbooks kept by the Manitoba Dairy Branch. Newspaper clippings related to the Wilson Milk Commission are found in the scrapbook dated 1917-1920. Unfortunately the specific newspaper and date are not documented. The headline for this clipping is: "Ideal Delivery Conditions Would Reduce Cost of Milk," c. January, 1918.

[100]In his testimony to the Wilson Milk Commission, one dairy producer, Mr. St. John estimated that it cost him 37 cents a gallon to produce winter milk. Two years previously, it had cost 18 cents per gallon. See: AM, Animal Industry Branch. Manitoba Dairy Branch Scrapbook dated 1917-1920. The headline for this clipping is: "Solution for High Milk Prices," c. January 1918. The Commission, consisting of W. A. Wilson, General Manager of the Saskatchewan Co-operative Creameries Co., Gertrude Code, representing consumers, and W. J. Cummings, a dairy producer, was appointed by J. D. McGregor, the Western Representative of the Food Controller in late 1917 to investigate "conditions appertaining to the supply, distributing and price of milk to the citizens of Winnipeg." It held several days of hearings in January, 1918, during which it heard testimony from representatives of the city's two creameries, dairy producers, and

The acute shortage of farm workers during the war made the difficult economic situation in the dairy industry even more serious.[101] Dairy farming was a labour intensive enterprise which required the daily availability of milkers, as opposed to the more seasonal demands for hired help associated with straight grain farming. Dairy farmers found it almost impossible to find experienced milkers, and even when their services could be secured, they commanded much higher wages than those paid prior to 1914.[102] Some dairy producers hired women to help with the milking. This tactic provided some economic relief, since they were able to pay female farm labourers less than their male counterparts.[103] However, even then, they had difficulty recruiting enough female workers

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consumers. The Committee's report was submitted to City Council by McGregor on January 26, 1918. Based on this report, McGregor set the consumer price for milk at 13 cents per quart or 7 cents per pint for the period between February 1, 1918 and May 15, 1919, and recommended that another committee representing the same three sectors be appointed immediately. One of its duties would be to set the price of milk for the period beginning May 16, 1919. CWA, Health Committee Files, Pre-1920 Health Special Committees, file # 1671 re: milk supply. This file contains all of the correspondence related to the Wilson report as well as the report itself.

[101]Thompson, *The Harvests of War*, 62-63;86-87.

[102]CWA, Health Committee Communications, October 16, 1916. In his September report to the Health Committee, P. B Tustin notes that dairy farmers were having problems finding trained milkers to work for them. See also: AM, Animal Industry Branch, Manitoba Dairy Branch Scrapbook dated 1917-1920. The headline for this clipping is: "Ideal Delivery Conditions Would Reduce Cost of Milk," c. January 1918. The monthly wages for a male farm worker had increased from $30-40 per month to $50 per month between 1916 and 1918.

[103]Captain Max Meincke, who owned a large dairy in Headlingly, reported that he was able to hire female farm workers at a wage of $40 per month. He also stated that he would hire more women if they were available. See: AM, Manitoba Dairy Branch Scrapbook dated 1917-1920. The headline for this clipping is: "Ideal Delivery Conditions Would Reduce Cost of Milk," c. January 1918.

to meet their needs because other sectors of the economy were competing for the same pool of workers.[104] All of these factors created significant economic and personal hardship for farmers involved in the dairy industry. As P. B Tustin observed in 1916:

> The prospect for the ensuing year does not look good under the present conditions; a number of dairymen are contemplating reducing or disposing of their herds, on account of experiencing so much difficulty since the new year in regard to the labor question. There is no doubt that the dairyman's usually hard life has, in many cases, become almost intolerable.[105]

When the Wilson Milk Commission held public hearings into the price of milk in early 1918, many milk dairy producers testified that they were on the verge of bankruptcy. Others had already dispersed their herds and gone out of the business.[106]

The economic crisis in rural Manitoba also seriously hindered the health department's campaign to persuade all raw milk producers to voluntarily tuberculin test their dairy herds. In more prosperous times, the argument that higher priced milk from tested herds could compensate dairy producers for the loss of tuberculin reactors appeared to have provided the necessary incentive. However, during the war, this was not the case. A decline in the number of tuberculin tested herds was observed. Even dairy producers

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[104]John Herd Thompson notes that, in Western Canada, women were not as extensively employed in industry as was the case in Eastern Canada. However, the shortage of male workers in all sectors of the Western Canadian economy enabled women to move into paid positions such as clerical workers, teachers, and civil servants. Thompson, *The Harvests of War*, 110.

[105]CWA, Health Department, *Annual Report* (1916), 98.

[106]AM, Animal Industry Branch, Manitoba Dairy Branch Scrapbook dated 1917-1920. See newspaper clippings: "Solution for High Milk Prices,", "Ideal Delivery Conditions Would Reduce Cost of Milk,", "Evidence Shows Creamery Receives Profit on Milk Above Spread Fixed by Law,". All clippings are c. January 1918.

who had participated in this program in the past were refusing to have their herds retested "on economic grounds."[107] It was more expensive to produce milk from tuberculosis free herds, and the public was now indifferent to the benefits of purer milk, or at least unwilling to pay a higher price for it.[108] Even when the number of tuberculin tested herds rose from three to ten in 1916, most of this milk was delivered to the Municipal Hospitals and the Babies' Milk Depot and did not significantly improve the safety of the milk delivered to the typical Winnipeg household.[109]

Winter milk famines also had a negative impact on the health department's efforts to create a pure milk supply for the city. Winnipeg experienced winter milk shortages even prior to the First World War because it was difficult and expensive to sustain milk production over the entire calendar year. The highest milk production occurred during the spring and summer soon after the calving season. Cattle could be provided with the food supply necessary to sustain high levels of milk production during this period through a combination of pasture grazing and supplemental feedings of oats or other feed grains. Winter milk production could only be sustained by providing the cattle with a total ration of high quality feed and by keeping them in warm barns as much as possible. Even then, milk production invariably dropped off and only picked up again in the spring after the cattle had again calved and entered a new cycle of lactation.

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[107]CWA, Health Department, *Annual Report* (1914), 112; Health Department, *Annual Report* (1916), 18.

[108]CWA, Health Department, *Annual Report* (1915), 96.

[109]CWA, Health Department, *Annual Report* (1916), 93.

Winter milk shortages occurred regularly between 1912 and 1922.[110] During the late fall and winter of 1911 - 1912, a severe milk shortage necessitated the importation of milk from as far away as Minneapolis and St. Paul.[111] The labour and economic crises during the war exacerbated this problem. At times, the winter milk shortages were so severe that the citizens of Winnipeg experienced "milkless days" where no milk was available for sale in the city.[112] In 1918, a milk famine was avoided only by producing "milk" reconstituted from milk powder, butter and water.[113]

An inevitable outcome of the winter milk shortages and the dramatic rise in the cost of producing milk during the war was a sharp increase in the consumer price of milk. This was an extremely contentious issue in Winnipeg, and particularly so amongst members of the city's working class. Dairy producers routinely charged more for winter milk to compensate for the higher costs associated with its production.[114] Although this

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[110]An article reporting the retirement of Provincial Dairy Commissioner L. A. Gibson in 1945 stated: "Two or three years before Mr. Gibson entered the government service [1915] the milk industry had men scurrying all over Minnesota and Dakota to get enough milk for the fluid milk market in Winnipeg. In the winter months an average of a carload a day used to come from Minnesota." See: AM Animal Industry Branch, Manitoba Dairy Branch Scrapbook.1921-1943. Clipping from *Winnipeg Tribune*, undated article entitled Personality Parade, c. 1945.

[111]CWA, Health Department, *Annual Report* (1912), 17. In the winter of 1917, the Department of Public Health's Annual report noted that the usual winter milk shortage had been avoided.

[112]CWA, Health Department, *Annual Report* (1920), 95.

[113]CWA, Health Department *Annual Report* (1922), 57.

[114]The question of how to price milk and when to charge a higher price for it, if at all, generated considerable debate in the farming community, and no doubt amongst consumers as well. Some farmers believed that the same price should be charged year

was no doubt a reasonable practice from the producers' perspective, winter was often a time of higher unemployment for the working class. Even families who could generally afford to purchase milk during the summer found the winter milk prices difficult to manage within their financial resources. As well, both dairy producers and members of the working class believed that the city's two creameries, the Crescent Creamery Co. and the City Dairy, exploited them; on the one hand by paying farmers as little as possible for milk shipped to them, and on the other hand by charging as high a price as possible to the consumer.[115] In the years leading up to the First World War, milk prices averaged

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round, with the price being set sufficiently high enough to enable the producer to recoup the higher costs associated with milk production during the winter. Most dairy producers, however, believed that winter milk should be priced higher than summer milk. See, for example: CWA, Health Committee Files, Pre-1920 Health Special Committees, file # 1671 re: milk supply. AM, Animal Industry Branch, Manitoba Dairy Branch Scrapbook dated 1917-1920. Undated newspaper clipping from *Farm and Dairy* "City Milk Supply."

[115]The whole issue of milk prices in Winnipeg during the First World War is too complex to be addressed in this thesis. It was, in fact, one of the factors which exacerbated the political debate between labour and capital, particularly between 1916 and 1918. The Crescent Creamery Co, Winnipeg's largest milk processing plant, was the target of considerable hostility and bore the brunt of criticism from labour politicians and contributors to *The Voice*, Winnipeg's labour newspaper. Also subject to critical commentary during the war years was W. J. Hanna, the Federal Food Controller, who was blamed for the high price of most consumer goods. The Wilson Milk Commission and a subsequent report authored by R. D. Hughes both recommended the establishment of one central milk processing plant in Winnipeg. This step, it was hoped, would reduce the cost of both the processing and distribution of milk in the city and result in a reduction of the price charged to consumers. In order to ensure that the Crescent Creamery Co. would not establish a monopoly by becoming Winnipeg's only milk processing plant, A. A. Heaps, a labour member of Winnipeg's City Council, proposed that a Municipal Milk Plant be established, and that the facilities of the two dairies then operating in the City be taken over by the City. This proposal was narrowly defeated during the civic election of 1919. Sources: *The Voice*, *The Manitoba Free Press*; CWA, Health Committee Files, Pre-1920 Health Special Committees, files # 1671 and 1607 re: milk supply; Thompson, *The Harvests of War*.

approximately 10 cents per quart.[116] In November, 1916, the Crescent Dairy increased the price of milk to 11 cents per quart.[117] After the Wilson Milk Commission delivered its report in 1918, the Western Representative of the Food Controller, J. D. McGregor, set the price of milk at 13 cents per quart.[118] By 1920, the price had risen to between 15 and 16 cents a quart.[119]

The net effect of the crisis in the agricultural sector, the winter milk famines, and the controversy over the war-time pricing of milk was that Winnipeg's health officials and aldermen could not enact new regulations to safeguard the quality of the city's milk supply because these measures would both increase the price and reduce the supply of milk. More stringent regulations regarding pasteurization and tuberculin testing were perceived by many as unnecessary measures that forced small dairy producers out of business and increased the monopoly of the large milk processors. It would be, Tustin concluded in 1918, "economic suicide" to put any further pressure on dairy producers or

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[116]Sutcliffe, "Economic Background of the Winnipeg General Strike,"139.

[117]*Winnipeg Telegram.* "Crescent Milk Advances in Price Once Cent Per Quart Bottle," November, 30, 1916. This full page advertisement inserted by Crescent Creamery included a lengthy explanation as to the necessity of this measure. The advertisement's defensive tone confirms suggestions elsewhere that Crescent Creamery was the target of considerable criticism for its business practices. In part, the advertisement states: "As the largest handlers of Milk in Winnipeg, we are frequently made the victim of that popular dislike almost invariably visited on the 'Middle Man'."

[118]CWA, Health Committee Files, Pre-1920 Health Special Committees, file # 1671 re: milk supply.

[119]AM, Animal Industry Branch, Manitoba Dairy Branch Scrapbook dated 1917-1920. Address Delivered by L. A. Gibson, Dairy Commissioner at the Saskatchewan Dairy Convention, January, 1920.

the public by enacting new dairy regulations or strictly enforcing those currently in place.

While male health officials, businessmen, politicians, and price controllers continued to take the lead role in regulating the quality and prices of Winnipeg's milk supply, women's influence as consumers also became more prominent. In 1916, a delegation from the Local Council of Women appeared before the city Council to protest the rising cost of milk, bread, and other essential food items.[120] Two letters advocating more stringent milk inspection regulations and the tuberculin testing of dairy cattle were received from the Women's Auxiliary of the Winnipeg Anti-Tuberculosis Society in 1918.[121]

Another notable development was the appointment of Gertrude Code to the Wilson Milk Commission, struck in 1917 to investigate the quality and price of Winnipeg's milk supply. Code purportedly represented the interests of all women in their role as milk consumers. However, her solidly middle class background, and her commitment to social reform make it more likely that she represented the interests of the middle class.[122] Code's effectiveness even in this role may well have been compromised

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[120]"Council Hears Protests on Rising Costs," *The Voice*, November 3, 1916, 5.

[121]CWA, Health Committee Minutes for March 21, 1918, letter from Charlotte E. Galloway; Health Committee Files, Pre-1920 Special Committees File #1607 re: milk supply, letter from Edith M. Fletcher dated December 12, 1918.

[122]Gertrude Code was the daughter of E. L. Drewry, a wealthy Winnipeg businessman and philanthropist. In 1937, she became President of the Board of Management of the Margaret Scott Nursing Mission. For a brief biography of E. L. Drewry, see: Bumsted, *Dictionary of Manitoba Biography*, 71. For information related to the testimony of the two women who appeared before the Wilson Milk Commission, see: AM, Manitoba Dairy Branch Scrapbook dated 1917-1920, unnamed newspaper article "Suggest Methods to Cheapen Milk." Their participation in the hearings as

by the constraints of gender. Newspaper accounts of the Commission's hearings indicate that she played a far less active role in questioning those appearing before the Commission than did her two male counterparts.

Even within the middle class, women's opinions about the health department's dairy policies were divided. Two women, Mrs. A. A. Perry and Mrs. Severen, publicly stated their opposition to pasteurized milk when they appeared as witnesses before the Wilson Milk Commission. Apparently, many middle class women in Winnipeg shared their opinion. John E. Tooth, who worked for several years in a variety of capacities for Crescent Creamery in Winnipeg, states that physicians played a major role in shaping women's opposition to this public health measure. "At this time," he wrote in his memoirs, "there was a lot of discussion as to the value or necessity of pasteurized milk, sixty four dairymen were selling it raw, and Doctor Gordon Bell was vehemently opposed to all forms of pasteurization and the ladies of Crescentwood and River Heights believed in him implicitly."[123]

However, despite a slightly more prominent presence on the public stage during this era, female social reformers and milk consumers held limited power. Although they could keep themselves informed and even participate in the public debate about the safety, price, and availability of milk, they could not determine the outcome. Their true

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representatives of the city's milk consumers was balanced by the attendance of Mr. Clark of the Social Welfare Commission, who described the plight of poor people, and Mr. W. H. D'Arcy, who testified on his own behalf.

[123]Tooth, "Sixty years in Canada." See also: Gray, *A Boy from Winnipeg,* 67. Gray states that his mother believed that all of the food value in milk was destroyed during the pasteurization process.

"humble task" was to re-adjust their domestic arrangements, not only to follow the suggestions of the Food Controller, but to keep food on the family table .[124]

Unfortunately, the war-time crisis regarding Winnipeg's milk supply did not merely create an interval where the quality of the milk supply remained static. All evidence points to the fact that there were major problems with the purity of milk during this period. Higher milk prices resurrected the spectre of the small dairy producer, whose presence in the retail milk trade had declined significantly in the years prior to 1914. Other equally discouraging indicators of the decline in the quality of Winnipeg's milk supply emerged during and immediately after the First World War. Less milk was pasteurized, and there were more prosecutions for adulterating milk. A small increase in the over-all tuberculosis mortality rate was observed [Figure 3-1], and milk-borne outbreaks of typhoid and scarlet fever were more frequently reported [Figure 3-2].[125] The health department's more lenient approach to the regulation of dairy producers between 1914 and 1919 carried a significant risk to the health of the city's hard pressed citizens.

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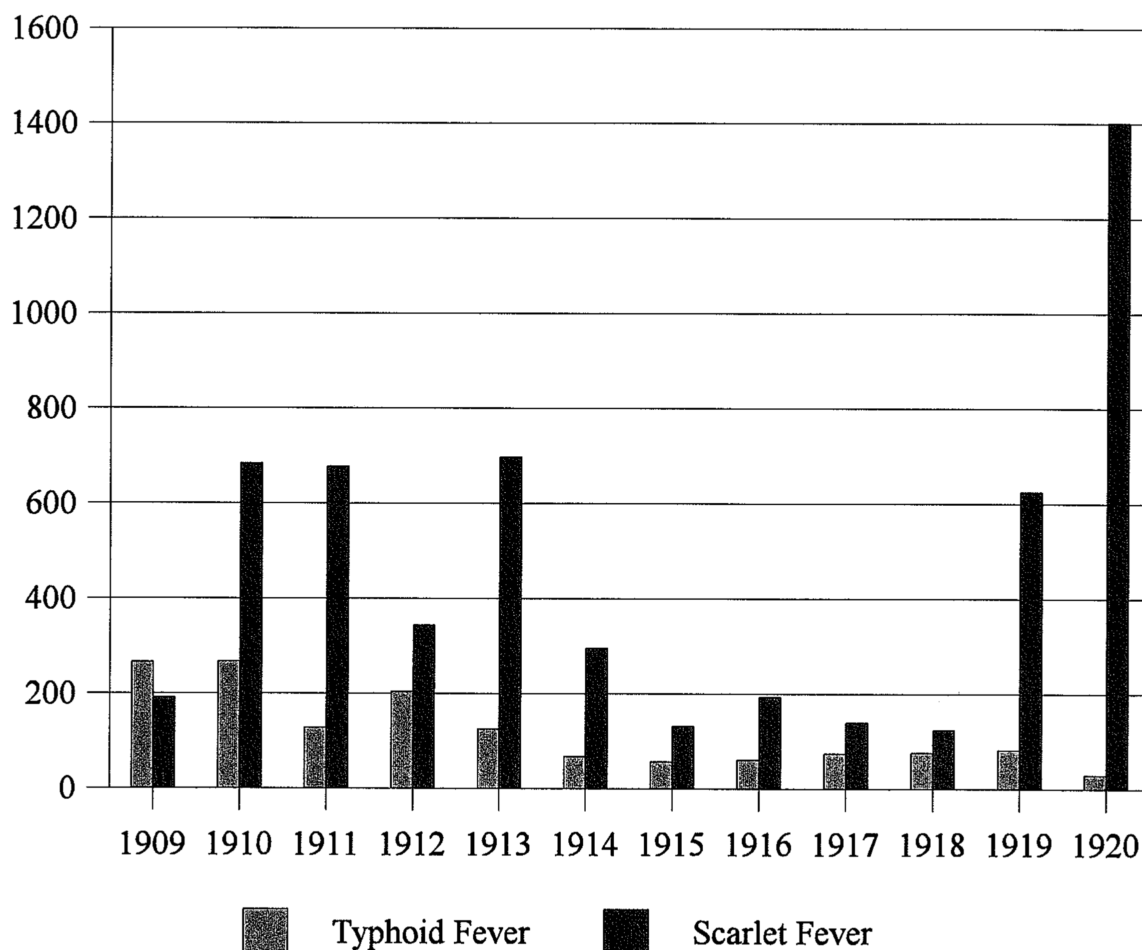
[124]CWA, Report of the Milk Committee Appointed by the Western Representative of the Food Controller for Canada, January 26, 1918. Health Committee Files, Pre-1920 Special Committees File #1671 re: milk supply.

[125]CWA. Re: tuberculosis mortality rates, see: Health Department, *Annual Report* (1916), 17. Re: decline in proportion of pasteurized milk, see: Health Department, *Annual Report* (1916), 18, 95; Health Committee Communications, File # 1607, Report of the Milk Committee appointed by the Western Representative of the Food Controller for Canada, January 26, 1918, p. 1; Re: prosecutions for adulterated milk, see: Health Department *Annual Report* (1915), 94-95; Health Department, *Annual Report* (1922), 57. Re: increase in milk-borne infections, see: Health Department, *Annual Report* (1916), 11; Health Department, *Annual Report* (1917), 8-9; Health Department, *Annual Report* (1918), 7-8; Health Department, *Annual Report* (1919), 85-86.

Figure 3-2: Typhoid Fever & Scarlet Fever Incidence Rates/100,000 Pop.: Winnipeg 1909-1920



Source: CWA, Health Department, *Annual Reports*, 1909-1920.

In the immediate post-war period, Douglas re-asserted the health department's mandate to protect the public's health, and mounted an aggressive campaign to clean up Winnipeg's milk supply. He abandoned the educational focus that had characterized the department's pre-war dairy policy, stating that unrepentant repeat violators "would have interpreted such action as a sign of weakness on our part and an indication that we were

desperately anxious to keep them in business."[126] Pledging to eliminate "undesirables . . . without any question of sympathy or sentiment," Douglas turned his attention to the stricter enforcement of existing regulations. [127] A new by-law, passed in March, 1918, enabled city officials to cancel the licenses of dairy operators and milk vendors found guilty of three infractions of the city's dairy regulations. Previously, repeat offenders had merely paid fines and continued in the business.[128]

In 1920, Douglas and the department's new chief dairy inspector, E. C. Brown, embarked on a carefully orchestrated campaign to eliminate the sale of raw milk from non-tuberculin tested cattle in Winnipeg. The minimum score in the Dairy Card system was increased from 350 to 375 out of possible total of 500 points [Figure 3-3]. Dairy producers scoring below the minimum were denied a dairy license.[129] The Health department planned to increase the minimum score to 400 in 1921, but this measure proved impossible to implement. Only tuberculin testing of the dairy herd would enable the majority of milk producers scoring between 375 and 399 to achieve a score of 400. As the department noted in its *Annual Report*:

> While the intention of the 1920 (Health) Committee was to raise the score to 400, yet it will be noted that 55 of the 80 dairies scored under 400. . . . This means that fully one-half of the dairies would have to make a gain of 25 to 30 points this year in order to reach 400, and practically the only

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[126]CWA, Health Department, *Annual Report* (1920), 97.

[127]CWA, Health Department, *Annual Report* (1920), 97.

[128]CWA, Health Department, *Annual Report* (1916), 83-85; Health Department, *Annual Report* (1918), 19.

[129]CWA, Health Department, *Annual Report* (1920), 96.

> method by which this could be done would be by means of the tuberculin test, application of which would be voluntary. The difficulty of having one dairyman do something which might not be required of another can be imagined; and no legal enactment could be framed to enforce such a condition.[130]

Knowing that no amount of vigilance on the part of the health department could ensure that raw milk from untested herds was safe for human consumption, Winnipeg's health officials again pressed for a by-law requiring that all milk from untested cows be pasteurized prior to its sale within the city limits.[131] The time for this measure, they argued, was right. Only 2000 cattle required testing, and the tests could be scheduled during the summer when the risk of creating a milk shortage was minimal.[132] Only the inability to compensate dairy producers stood in the way of mandatory tuberculin testing.[133]

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[130]CWA, Health Department, *Annual Report* (1920), 96.

[131]CWA, Health Department, *Annual Report* (1920), 104-105; Health Department, *Annual Report* (1921), 54.

[132]CWA, Health Department, *Annual Report* (1920), 113.

[133]CWA, Health Department, *Annual Report* (1921), 54.

Figure 3-3: City of Winnipeg Dairy Score Card

CITY OF WINNIPEG HEALTH DEPARTMENT

FOOD AND DAIRY DIVISION

Score Card for Production of Sanitary Milk

No. 211 — Score

Name — Class

Date — Scored by Inspector

GENERAL. 100	Score
Location, high and dry, well drained	
Adaptability for dairy purposes	
Arrangement of buildings	
Barnyard	
Separate horse stable	
Pigs and poultry houses well regulated	
Location and construction of privy	
Disposal of household refuse	
Location and protection of water supply	
Suitability of pasturage	
TOTAL	

THE STABLE. 100	Score
External appearance	
Concrete foundations	
Concrete floor	
Drainage	
Cubic air space per cow	
Light	
Ventilation	
Smooth interior finish	
Construction of stalls	
Arrangements for feeding and watering	
TOTAL	

THE COWS. 50	Score
Suitability for dairy purposes	
Condition	
Tuberculin tested herd	
Reactors immediately removed	
Additional cows isolated until tested	
TOTAL	

MILK HOUSE. 50	Score
Separate from stable	
Concrete foundation and floor	
Smooth finish	
Drainage	
Suitable for bottling milk	
TOTAL	

CLEANLINESS. 100	Score
Surroundings, clean and neat, free from mud holes, rubbish and manure	
Milk House, frequently whitewashed, clean, neat, nothing stored there except milk and utensils	
Stable, frequently whitewashed, free from all extraneous matter	
Water supply, clean conditions, around the well	
Cows, clean and comfortable, well groomed, bedded with clean straw	
Cows' udders, clean, washed before milking	
Milking suits and stools clean	
Utensils clean and well cared for	
Delivery outfit clean and neat	
Employees clean in person and habits	
TOTAL	

METHODS AND EQUIPMENT. 100	Score
Regularity in removing manure from the stable	
Regularity in grooming, feeding and attending to cattle	
Milk carried immediately to milk house and properly strained, cooled and stored	
Boiling water or steam for sterilization purposes	
Screen doors and windows, protection from flies	
Sanitary fittings and appliances for stable	
Sanitary fittings for milk house	
Sanitary utensils and small-top pails	
Sanitary cooler and tank	
Sanitary milk bottling outfit	
TOTAL	

TOTAL OF 60 ITEMS. 10 POINTS ALLOWED FOR EACH ITEM. MAXIMUM 600.

480 or more is Excellent. Between 440 and 480 is Very Good. Between 400 and 440 is Good. Between 360 and 400 is Fair. Under 360 is poor.

The solution to this problem lay in the hands of the federal government. Under revised regulations passed in 1917, the federal government provided veterinary inspectors, at no cost, to tuberculin test dairy cattle producing milk for consumption in participating communities. Partial compensation was provided for cattle destroyed under this program. Distinctions were drawn between dairies producing raw milk and those producing milk for pasteurization. Cities participating in the program were required to enact by-laws prohibiting the sale of raw milk from untested cows.[134] Another new by-law, passed by Council in 1922, created the appropriate legal mechanism for Winnipeg's participation in the Federal program [Table 3-1]. Although federal regulations regarding dairy barns and milk houses were still more stringent than those set forth in the previous city by-laws, Douglas was confident that ninety percent of the dairies supplying milk to Winnipeg could be brought up to federal standards within the year.[135]

The magnitude of the tuberculosis problem in dairy cattle became apparent once widespread tuberculin testing was initiated in the wake of this by-law. General estimates of the prevalence of tuberculosis in dairy cattle supplying milk to Winnipeg had, as far back as the late nineteenth century, ranged from 30 to 35 percent.[136] However, the

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[134]Dominion of Canada, "Regulations Relating to Tuberculosis"; CWA, Health Department *Annual Report* (1921), 54; Church, *An Unfailing Faith,* 125-126.

[135]CWA, Health Department *Annual Report* (1921), 54.

[136]E. C. Brown, Winnipeg's Chief Dairy Inspector, reported that tuberculin testing in Saskatoon, which had commenced in 1915, resulted in a reported 8 - 10% reaction rate. Tuberculin testing in Winnipeg as early as 1895 had revealed a bovine tuberculosis prevalence of approximately 30%. Calculations of prevalence from data on tuberculin testing between 1909 and 1911 indicates a prevalence of bovine tuberculosis in dairy herds supplying milk to Winnipeg of between 35 and 38%. See: CWA, Health

problem was far worse. Winnipeg's comprehensive tuberculin testing program revealed that 62.5% of the dairy cattle initially tested under the new by-law were tuberculin positive. Only two of the one hundred herds tested were tuberculin negative. Both were new herds which had been established from tuberculin negative stock. Of the established dairy herds supplying milk to the city, not one was found to be tuberculosis free.[137]

Conclusion

In the three decades between 1882 and 1922, the campaign to clean up Winnipeg's milk supply focussed almost exclusively on the eradication of one pathogen, *M. bovis*. Significant resources, both human and fiscal, were expended to pursue a regulatory strategy that required continuous inspections by city dairy officials, the drafting of 14 dairy by-laws, several court appearances, and countless debates in city council. These efforts met with limited success. Although the dairy industry was both better managed and better regulated by 1922, milk-borne diseases such as typhoid fever and scarlet fever continued to occur in Winnipeg [Figure 3-2].

Even in the realm of tuberculosis control, the health department's clean milk campaign fell short of its objectives. The reported prevalence of *M. bovis* in dairy cattle supplying milk to Winnipeg actually doubled between 1895 and 1922. Eradication of bovine tuberculosis had clearly not been achieved. Indeed, the emergence of the large dairy producer and the establishment of large dairy herds, which had forced the small producer out of business, likely contributed to the increased prevalence of tuberculin

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Department, *Annual Report* for the years 1909, 1910, 1911, and 1920.

[137]CWA, Health Department, *Annual Report* (1922), 64-67.

reactors during that period. One infected animal housed in a barn with the rest of the cattle during the winter months would certainly expose the other animals to *M. bovis* and increase the number of reactors in the herd.

Although tuberculosis mortality declined between 1910 and 1920 from 114/100,000 to 73/100,000 population, it could be argued that this improvement was not achieved through the city's dairy policies. City health officials did not differentiate between *M. bovis* cases and *M. tuberculosis* cases in its mortality statistics. It was simply assumed that those who died from non-pulmonary tuberculosis were more likely to have been infected with *M. bovis*. This was an invalid assumption, even at that time. Non-pulmonary forms of tuberculosis can also be caused by *M. tuberculosis*. Children, in particular, are more likely to develop non-pulmonary tuberculosis in response to a *M. tuberculosis* infection.[138] The sites of the reported tuberculosis infections were not an accurate measure of the effectiveness of city's dairy policies. Only morphological examinations of the causative organism, which were technically possible at that time, could have provided this information.

Given that this was the case, it is even more difficult to understand the single-mindedness with which the city's dairy policies were shaped to prevent the transmission of tuberculosis from dairy cattle to humans. The vast majority of tuberculosis cases in Winnipeg, even amongst children, were pulmonary rather than non-pulmonary, and the reservoirs of these infections were other humans with pulmonary tuberculosis rather than infected milk [Figure 3-4]. Perhaps, as Barbara Rosenkrantz suggests, public health

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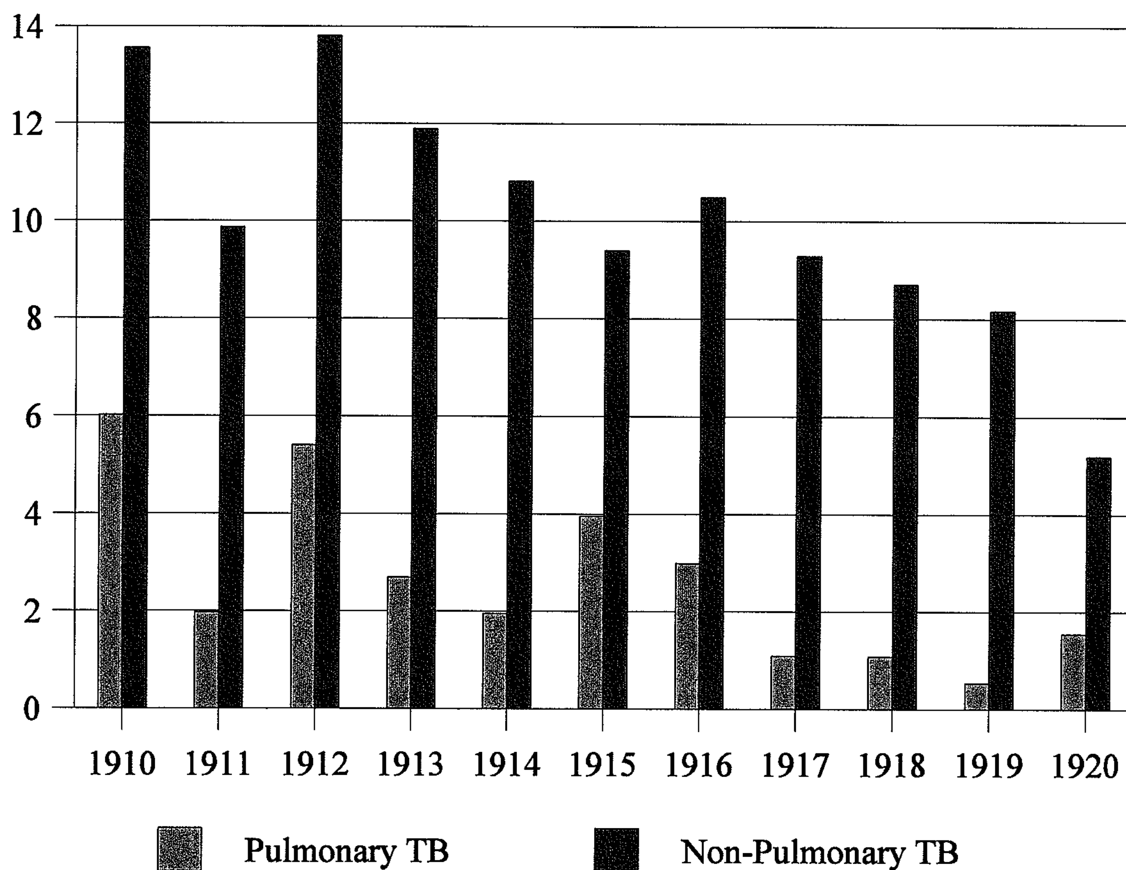
[138]Chin, *Control of Communicable Diseases Manual*, 521.

officials preferred to adopt a narrow approach to tuberculosis control because this both highlighted their scientific competence and enabled them to avoid confronting the more nebulous social causes of tuberculosis such as poverty.[139]

Figure 3-4: Pulmonary and Non-Pulmonary Tuberculosis Mortality Rates/100,000 Pop. in Children 0-4 Years of Age: Winnipeg, 1910-1920



Source: CWA, Health Department, *Annual Reports*, 1910-1920.

The limited success of the campaign to eliminate *M. bovis* through rigorous tuberculin testing becomes even more problematic when one considers that pasteurization would have eliminated it and many other pathogens from the city's milk supply. Yet,

[139]Rosenkrantz, *Public Health and the State*, 170-179.

universal pasteurization was not acknowledged by the health department as the most effective solution to the problem of milk-borne diseases until 1919. Even then, the city chose to pursue a more conservative policy of only requiring pasteurization of milk from non-tuberculin tested cows. In Winnipeg, as elsewhere, the debate about the most effective way to eliminate pathogens, particular *M. bovis* from the milk supply was taken up by various interest groups based not so much on scientific knowledge, but on what this knowledge could do to advance or hinder other political, professional or economic agendas. Professional and scientific differences of opinion within and amongst physicians and veterinarians created confusion in the minds of the public and obscured the most effective solution to the problem of contaminated milk.

For federal and provincial politicians, the debate was not so much about science as it was about votes. In a predominately rural country, political support for tuberculin testing in the absence of compensation programs for dairy producers was political suicide, and the politicians knew it. The scientific debate amongst physicians and veterinarians enabled the politicians to evade the obvious question of who should bear the cost for tuberculosis eradication in Canada's dairy herds. In the final analysis, the greatest single barrier to the universal pasteurization of Winnipeg's milk supply was its cost. Economic rather than public health arguments had carried the day.

Those who had the most to lose were held at arm's length from the political and professional battles about the creation of a safe milk supply. Dairy farmers lost countless valuable animals, if not their entire livelihood, as a result of the link made between *M. bovis* and human tuberculosis. Clean dairies, however important they might have been to

public health, clearly came at an exorbitant price for the dairy producer.

Milk consumers, too, became the victims of this campaign. The haunting spectre of countless vulnerable individuals being needlessly exposed to air-borne, not milk-borne tuberculosis while health officers, private physicians, and veterinarians debated the relative merits of certified versus pasteurized milk is a sobering reminder that scientific knowledge is both fallible and subject to political and economic agendas. Even if infected cows' milk was a factor in the etiology of human tuberculosis, it was likely a minor reservoir in a disease that finds its likeliest victims amongst the poor, the malnourished, and the overcrowded. Organized medicine and veterinary science had nothing to gain from lobbying for a living wage for the working poor or an end to material deprivation based on inequitable access to political and economic power. Neither did the politicians of the time. The pursuit of their own professional or political agendas caused them to advocate another, less effective, solution.

In the final analysis, one must ask if the regulatory strategy pursued by male politicians and health officials was the most important one to be waged at that time. Women, it appears, adopted a different set of priorities for public health programs. They turned their attention to those most affected by the city's appalling sanitary conditions. The organization and management of charitable nursing services for the poor was the legitimate realm of female social reformers. Here, freer from the constraints imposed by gender, Winnipeg's female social reformers carved out their own sphere of influence within the campaign to improve the public's health.

Chapter 4

Lay Women's Response to Winnipeg's Public Health Crisis: The Margaret Scott Nursing Mission, 1904-1942

Introduction

In 1938, Ethel Johns, editor of the *Canadian Nurse,* replied to a letter from Marjorie Baird, Superintendent of Nurses at the Margaret Scott Nursing Mission (hereafter, the Mission). In answer to several questions evidently posed by Baird, Johns stated that, in her opinion, the Mission was no longer capable of providing high standard community-based nursing care. Reflecting on what alternatives remained if the Mission's district nursing service was discontinued and the venerable philanthropic organization was disbanded, Johns recognized the dilemma that faced not only the Board, but also the community which the Mission had served for thirty-four years:

> Is it justifiable to change the purpose which was so dear to the heart of the founder? There is a real problem here. No one who was ever exposed to Mrs. Scott's influence can ever quite reconcile themselves to the disappearance of the Mission. I worked with many of the women whom she gathered about her and the spirit which animated them was admirable. This dynamic force ought not to be lost but it might be more productive if it could be turned into other channels.[1]

Assessments of the factors that motivated wealthy and middle-class Canadian women to devote their time and energy to philanthropic endeavours are shaped by the dimension of philanthropic work one chooses to focus upon. If a Marxist approach is adopted, then it is inevitable that the contribution female philanthropists made to social reform would be downplayed, even denigrated. In the paradigm of class conflict, the only

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[1]AM, The Mission Papers. MG10, B9, Box I. This typed letter has a pencilled notation on the top margin giving a date of Nov. 23, 1938.

real reformers would be those advocating revolution, a situation where, at least in the short term, the suffering of vulnerable populations would be increased. Few, if any of the Mission's leaders, even those more committed to political action, advocated social reconstruction which involved violence and class warfare.[2] However, an analysis which privileges the personal satisfaction and social prestige that "Lady Bountiful" attained through her charitable work also provides only partial insights into the motivations which animated the Mission's commitment to the nursing care of Winnipeg's sick poor.

During the time that the Mission provided nursing care to Winnipeg's sick poor, the beliefs and values of the city's female social reformers were shaped by the discourses of philanthropy, the social gospel, and maternalism. Although the Mission's own guiding philosophy remained firmly philanthropic, the values it shared with the social gospel movement and maternalism enabled it to recruit interested female social reformers to serve on its Board. All three discourses supported women's work in the public sphere. Visiting the sick poor had long been held as a responsibility of elite women.[3] Maternalism and the social gospel movement expanded the public roles available to women by emphasizing women's moral influence in the political sphere, and by transforming the individualized visiting of "Lady Bountiful" into "woman to woman" work which was carried out within organizations founded expressly for that purpose.[4]

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[2]Hutching, "'Mothers of the world.'"

[3]Kidd, "Philanthropy and the 'Social History Paradigm'"; Gerard, "Lady Bountiful,"183-210; Preston, "Lay Women and Philanthropy in Dublin,"74-85.

[4]For a further discussion of the impact of maternalism and the social gospel movement on women's public roles, see, for example: Christie and Gauvreau, *A Full-*

This chapter examines the contributions of the "dynamic" women who founded Winnipeg's first visiting nursing organization and, in so doing, contributed to the development of visiting nursing in Canada, and laid the foundations for state-sponsored public health nursing programs. It analyses the impact that philanthropy, maternalism, and the social gospel had on the women who joined the Mission's Board of Management, and how the convergence of these discourses created a unique opportunity for women to contribute in a meaningful way to the wider public health movement. It identifies the Mission's strengths and analyses its capacity to forge the psychological and organizational alliances that sustained it during nearly four decades of service to Winnipeg's poor. It also examines how the Mission's continued adherence to the tenets of philanthropy eventually limited the scope of its mandate and contributed to its closure. In the final analysis, the Mission's experience reveals much about the origins of Canadian public health programs, and about the role that women played in their development.

The Ideological Terrain of the Margaret Scott Nursing Mission

The Mission was founded in 1904 during one of Winnipeg's most serious typhoid epidemics. Margaret Scott and Elizabeth Lamont, Miss Rathbone's successor, had by then demonstrated the need for a permanent visiting nursing service to care for the growing number of poor and immigrant citizens living in Winnipeg. In response to the typhoid epidemic and the ongoing needs of the sick poor, a "group of interested women" gathered at the home of Mrs. A. M. Fraser to discuss the possibility of establishing a

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Orbed Christianity; Edwards and Gifford, *Gender and the Social Gospel*; Flanagan, "Gender and Urban Political Reform"; Huber and Lutkehaus, *Gendered Missions*; Koven and Michel, *Mothers of a New World*; Robert, *American Women in Mission.*

nursing mission in Winnipeg similar to those operating in other cities.[5] In late 1904, having received a grant from the city and a promise of $1200 per annum in continued support, these women founded the Margaret Scott Nursing Mission and took over administrative responsibility for Lamont and her assistant, Eliza Beveridge.[6]

To be accurate, men were also present at the meeting. However, the Mission was, for its entire existence, run by a female-only Board of Management. Men were only appointed to serve on the Advisory Board, and had little to do with the day to day management of the Mission. This gendered division of labour appeared to satisfy both the men and the women who supported the Mission. Speaking at the First Annual Meeting, E. L. Drewry was "glad to express his appreciation of the work being done by the ladies." Noting that "there were not many men present," he stated that "he knew that they were in their offices making money for the ladies to spend in this good work."[7]

The Mission's chronology (1904-1942), its presence in Winnipeg, its organizational structure, and the large number of women involved in its management all suggest that complex and multi-faceted social forces underlay individual decisions to devote time, energy and financial resources to its founding and maintenance. A

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[5]AM, The Mission Papers, MG10, Box VI. Undated letter from Mrs. A. M. Fraser. A copy of this letter is attached to the front of the Nov. 8, 1909 - October 10, 1920 Minute Book; MacVicar, *Margaret Scott: A Tribute.*

[6]AM, The Mission Papers, MG10, B9, Box VI, *First Annual Report* (1905), 6, 8.

[7]AM, The Mission Papers, MG10, B9, Box VI. Report of the October 31, 1906 Annual Meeting, published in an unnamed Winnipeg newspaper. The newspaper clipping was pasted behind the 1906 annual meeting minutes in the May 12, 1904- Oct. 24, 1906 Minute Book.

succession of social reform movements, including philanthropy, the social gospel, maternalism, and the emerging Canadian welfare state all played important roles in defining and shaping the Mission's work. These discourses, although distinct, were not mutually exclusive. To a greater or lesser degree, they all occupied the ideological terrain of early twentieth century Winnipeg. Despite important differences about priorities, methods, and goals, their adherents also shared important assumptions and were interested in the plight of similar vulnerable groups in society. Although considerable bodies of literature have analysed the impact of each of these social movements, less attention has been paid to the impact of their combined influence on social reform efforts.

Raymond Williams provided a useful approach to conceptualizing the connections between these competing discourses. Williams proposed that human culture consists of three co-existing discourses: the dominant, the residual, and the emergent.[8] Social processes are influenced by all three, with the dominant discourse exerting the greatest influence over social action. Within the social and temporal context of the Mission, it is clear that the dominant discourses driving social change were those articulated by the social gospel movement and maternalism.[9] The residual discourse, still powerfully

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[8]Williams, *Marxism and Literature.*

[9] For an analysis of the aspirations of the social gospel movement, see: Allen, *The Social Passion*; Cook, *The Regenerators*; Christie & Gauvreau. *A Full-Orbed Christianity.* For an analysis of the women's movement of the late nineteenth and early twentieth century, and of the role that this movement played in the creation of the modern welfare state, see, for example, Bock & Thane, eds. *Maternity and Gender Policies*; Koven & Michel, eds. *Mothers of a New World*; Ladd-Taylor, *Mother-Work.*

influential, was philanthropy.[10] The emergent discourse was that embodied in the rationalistic, interventionist, but yet-to-be-fully realised modern welfare state.[11] Each discourse defined health in a particular way and created unique boundaries around the acceptable limits of helping behaviour (Table 4-1). Each discourse also suggests a particular way of viewing the history of women's participation in the development of public health programs.

Table 4-1; Health Care and Social Reform: Residual, Dominant & Emerging Discourses: 1890-1942

Philanthropy	**Social Gospel**	**Maternalism**	**Modern Welfare State**
Goal:	Goal:	Goal:	Goal:
To demonstrate personal faith and conversion through social work.	To bring about God's Kingdom on earth for all people through social reform.	To use the superior moral strength of women to reform society.	To redistribute wealth and resources to further capitalist growth.
To alleviate suffering.	To eliminate suffering.	To eliminate the suffering of women and children.	To provide financial support to those groups more likely to suffer because of increased need or vulnerability.
To reduce class tension and unrest in order to maintain the status quo.	To reduce class tension and unrest by the transformation of society.	To create cross-class alliances between women to facilitate the transformation of society.	To reduce class tension and unrest by provision of basic necessities to those in need.
Constituency:	Constituency:	Constituency:	Constituency:
The poor. The sick. Women & children.	The poor. The sick. Women & children. Workers. Immigrants.	Women & children.	Women & children. Immigrants. Workers.

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[10]For a thoughtful review of the historiography of philanthropy, see Kidd, "Philanthropy and the 'Social History Paradigm,'" 180-192.

[11]See, for example: Naylor, ed. *Canadian Health Care and the State*; Owram, *The Government Generation*; Alan Sears, "Before the Welfare State,"169-188.

Philanthropy	Social Gospel	Maternalism	Modern Welfare State
Basis for Action:	Basis for Action:	Basis for Action:	Basis for Action:
Needs	Rights (based on citizenship).	Rights (based on difference) (vulnerability)	Rights (based on specific, demonstrated need)

Philanthropy: The Alleviation of Suffering Through Prayer and Action

In reviewing the historiography of philanthropy, Alan Kidd provides crucial insights into its meaning. He begins with the proposition that giving "is never altruistic."[12] Philanthropy maintained social distance.[13] It sought to alleviate the hardships of distant others, but not to eliminate them. To do so would, in fact, preclude the achievement of philanthropy's primary goal, which was the demonstration of personal faith through the rendering of good works to others.[14] Philanthropists expected that the recipient of their charity would exhibit deference. Charity, in fact, sustained rather than challenged the social and economic inequalities between the donor and the recipient. Within the discourse of philanthropy, the basis for action was needs, not rights.

Scott's pioneering work amongst Winnipeg's poor was inspired by her desire to serve God. Both her personal motto, Psalm 155:1, and her practice of ending all of her letters with the phrase "Yours in the Saviour's Service" reveal that her work amongst

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[12]Kidd, "Philanthropy and the 'Social History Paradigm,'" 183.

[13]Kidd, "Philanthropy and the 'Social History Paradigm'"; Gerard, "Lady Bountiful"183-210; Preston, "Lay Women and Philanthropy in Dublin,"74-85.

[14]Kidd, "Philanthropy and the 'Social History Paradigm'".

Winnipeg's poor was the outward manifestation of her personal faith.[15] The Mission was established to assist Scott in the care of the sick poor, an aspect of her work that she did not feel qualified to pursue by herself. The women who composed its first Board of Management incorporated Scott's guiding principles into the Mission's structure. Faith and prayer were the foundations upon which the Mission rested. This approach to the care of the sick poor was an important factor in eliciting the support of the public. In the words of one supporter:

> It was most refreshing to read the M.S.N.M. [sic] Report the other day & see how steadily & wonderfully the work grows. It is a standing rebuke to anyone who hasn't any use for prayer.[16]

The Mission's original By-Laws prescribed that meetings would be opened with the Mission's prayer, written by Mrs. Scott, and the Lord's prayer. This practice, which was re-affirmed after the Mission's re-organization in 1937, continued until its closure in 1943.[17]

The Mission's Board, like Scott, trusted in God's providence, and did not publicly solicit donations to support its work. Each annual report reiterated this policy, and over the course of its history, the Board never knowingly deviated from this principle. The Board also refused to accept from other organizations funding which had been acquired

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[15]This verse states: "If in trying to serve God I have been privileged to cheer and comfort others my highest aim has been attained." These words appeared below Scott's picture in almost all the the Mission's Annual Reports.

[16]AM, The Mission papers. MG10, B9, Box VI. Minutes of March 8, 1926.

[17]AM, The Mission papers. MG10, B9, Box V, Minutes of June 14, 1937; Box 6, *First Annual Report* (1905).

through charitable campaigns. Strict adherence to this policy ultimately contributed to the financial difficulties experienced during the last seven years of the Mission's existence. Although the Mission supported organized charitable work, and maintained a membership in Winnipeg's Central Council of Social Agencies, it never joined the All Charities Organization because of its annual fundraising campaign. Over time, the All Charities Organization, through the Federated Budget, became a major source of funds for its partner charitable organizations. This policy also complicated the Mission's ability to accept financial support from governments and non-governmental organizations. In 1917 and again in 1923, the Board notified City Council that it could not participate in the proposed Federated Finance scheme for city charities and needed a continued grant from the city's operating budget to remain in business.[18] In 1920, the Board waited to confirm an agreement with the Red Cross Society for a grant of $2500 per year for three years to employ two additional nurses until it was assured that the funds offered had not been secured through public fund raising campaigns.[19]

It is possible to change by-laws and funding policies, but the structure of the Mission's Board made this unlikely. Two presidents, Mrs. E. M. Wood and Mrs. William Robinson, were founding members of the Board. Two others, Mrs. R. T. Riley and Mrs. W. G. McMahon, joined the Board while Scott was still actively involved in the day to day work of the Mission. Together, these four women chaired the Board for the first

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[18]AM. The Mission papers. MG10, B9, Box IV. Minutes of May 14, 1917 and Nov. 1, 1923.

[19]AM, The Mission papers. MG10, B9, Box IV. Minutes of Feb 12, 1920.

thirty-three years of the Mission's existence. Even after her death, Scott's guiding principles were regularly affirmed:

> [A] worthy object, worthily and unselfishly carried out, makes its own appeal and never fails to commend itself to the sympathy and support of right thinking people, who will voluntarily rally around its maintenance. This has been the experience of the Margaret Scott Mission in the past and it will be unfailingly the experience of the future, provided we who conduct the Mission keep it up to its past standard of faithfulness, trust and efficiency.[20]

The fifth and last president, Gertrude (Drewry) Code, was instrumental in the re-organization of the Mission's Board, but she did not depart from its original value system. Indeed, much of Code's work was inspired by her determination to preserve and re-affirm the pious approach of the Mission's founders. Code ended many of her reports with the phrase "IN HIS NAME", echoing Margaret Scott's earlier practice. Other initiatives that demonstrated her desire to preserve the memory of Margaret Scott and other founders included the establishment of a library in memory of her parents, Mr. & Mrs. C. E. Drewry, at the Mission, and a project to document the Mission's history.

The strength of the Mission's commitment to the discourse of philanthropy is also evidenced by its lack of political action. It made no sustained effort to change the fundamental dynamics of Winnipeg society or to challenge the root causes of the suffering experienced by those the Mission served. In her report to the 1910 annual meeting, the Board's secretary, Louise Minty, articulated both the Board's awareness of the causes of Winnipeg's high child mortality rate and their unwillingness to use political means to reduce it.

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[20]AM. The Mission papers. Box VI, *Thirtieth Annual Report,* (1934): 6-7.

> Next we have an even easier and more local unsanitary condition to consider. The purity of the milk supply for the babies is essential. Much of the epidemic of last summer is directly traceable to this source. The remedy is twofold. Public supervision of purity of the source of supply is one. Public supervision of its purity after it reaches the consumer is the other. To attain the former strict legislation and its enforcement are essential. That opens up too large a field . . . for our present consideration.[21]

The Board's membership also reflected and reinforced its philanthropic emphasis. Social distance between Board members and the Mission's clients was always maintained. Most Board members resided in areas of the city at some distance from the homes of the Mission's patients. Of those Board members whose addresses are known, the majority resided "across the river" in the new southern neighbourhoods of Winnipeg.[22] Other members were drawn from middle class and upper middle class neighbourhoods in St. James, St. Boniface, Ft. Garry and West Kildonan. There is no evidence that a Board member ever resided in the Mission's primary catchment area located in Winnipeg's North End, or was recruited from the population that the Mission served.

Cultural differences also isolated the members of the Board from those they served. Board members whose origins can be identified were Anglo-Canadian or British. In contrast, the Mission's patients were primarily non-English speaking immigrants from

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[21] *Winnipeg Telegram*, Nov. 1, 1910.

[22] For a discussion of the geographic manifestations of social differences between the wealthy elite of early 20th century Winnipeg, who were primarily from Ontario or Great Britain, and the poor, who were primarily from Eastern Europe, see. Artibise, *Winnipeg*; Hiebert, "Winnipeg: A Divided City"; Hiebert, "Class, Ethnicity and Residential Structure."

central Europe, who dwelt on the other side of the significant cultural and language divide between the givers and recipients of nursing care. However, the Board's attitudes about the Mission's patients created other barriers. Board minutes, annual reports and newspaper accounts of the Mission's work were replete with references to "the poor," "those less fortunate," and, perhaps most telling of all "the desolate lot of impecunious strangers." [23] The psychological distance created by ethnicity, status, and material advantage erected social barriers more pervasive and more unassailable than language differences alone could ever create.

The value that Board members placed on personal philanthropy was also revealed by their faithful adherence to a policy of visiting the Mission's patients in their homes "to get in touch with the sick and poor."[24] This duty was formalized in 1908, when the mandate of the Visitors Committee was expanded from visiting "The Home" at 99 George St. to organizing home visits for Board members. Each month, two Board members were provided with names of suitable families by the Superintendent of Nurses. Board members had a distinct preference as to whom they would visit. In 1936, Mrs. Adamson complained that some of their visits were not useful, and in future, she recommended that their efforts be focussed on sick patients, not "people on relief."[25] The

[23]AM. The Mission Papers. MG10, B9, Box IV. This phrase appears in an undated newspaper account of the 1906 Annual Meeting pasted behind the meeting's minutes in the May 12, 1904- Oct. 24, 1906 Minute Book.

[24]AM, The Mission Papers, MG10, B9, Box IV. Minutes of Monthly and Annual Meetings Nov. 8, 1909 - October 19, 1910.

[25]AM. The Mission papers, MG10, B9, Box V. Minutes of Dec 14, 1936.

names of those visited were sometimes entered in the Minutes of Board meetings. Most, if not all those listed had surnames suggesting a British origin.[26] Some patients were visited on a regular basis. The Board Minutes of 1910-1911, for example, contain several references to a Miss B., in whom the Board had taken a particular interest, and had tried to help in various ways.

In keeping with their philanthropic emphasis, Board members sometimes intervened directly in the affairs of the patients they visited. In 1908, for example, a member of the Auxiliary adopted a young boy who had been a patient of the Mission. Several Board members had visited this child, and their interventions had resulted in his removal from his family. The Board Minutes of 1934-35 regularly mention Bill C., a paralysed youth who was sent to Robertson Camp in Gimli through the efforts of the Board.

Visiting the Mission's patients was highly valued and personally rewarding work for Board members. The obituary of Mrs. A. F. D. MacGachen, a Board member from 1908-1917 emphasizes the rewards that personal interaction with the Mission's patients provided for these women:

> In addition to her work in these organizations, she was especially loved for her interest and sympathy for the sick and poor of the city; and many homes were brightened by her frequent visits, which she paid in a very unobtrusive way.[27]

Personal and spiritual growth were valued outcomes of these women's philanthropic

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[26]See, for example, AM. The Mission papers, MB10, B9, Box IV. Minutes of Nov. 12, 1917; Box V. Minutes of Dec. 10, 1934.

[27]*Winnipeg Telegram*, April 16, 1918.

activities at the Mission. In her farewell address to the Board, read at the annual meeting she was too ill to attend, Board President Georgianna Wood reflected on the personal growth she had experienced as a result of her work for the Mission.

> Speaking for myself I can say with abundant joy and satisfaction that my connection with the Mission, and contact with Margaret Scott, has been in my life an inspiration and a great privilege, and has afforded me the opportunity of seeing ever near the heart of things both human and divine.[28]

The Board minutes also reveal that, as was the case with other groups of philanthropic women, social support was an integral part of their working relationship. The minutes regularly document congratulations extended to women for achievements in other arenas, cards and flowers sent in times of illness, and condolences extended in times of bereavement. The opportunity to use both domestic and professional skills outside the family home was also valued by these women. For some, including Annie Bond, Bessie [Elizabeth] Moody, Mildred McFetridge, Della Mitchell, Lillian Harris and Mrs. D. A. MacGibbon, working on the Mission's Board was the continuation, through voluntary work, of a professional career in nursing or home economics cut short by marriage and family responsibilities.

The tension between altruism and ego, another element of the discourse of philanthropy, is evident in the language of the minutes and annual reports.[29] The "unobtrusiveness" of visits by Mrs. MacGachen and others, and their regular description

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[28]Mrs. E. M. Wood's letter of resignation as president of the Mission. Undated, but likely Jan. 1920. A copy of this letter is in the possession of the author.

[29]Kidd, "Philanthropy and the 'Social History Paradigm'".

of their work as "quiet" and "nothing special" straddles the boundaries between modesty and pride.[30] These women, as befitted their social status and gender, did not wish to draw attention to themselves. At the same time, they were "proud of [the Mission's] lowly part in the life of the city" and proud of their part in the Mission's work, which they saw as a natural outcome of their faith and their station in life.[31]

Because Board members believed that charity should only be provided to the deserving, they took great pains to adhere to the principles of self-help. Every effort was made to ensure that the Mission's work did not "pauperize" the individuals and families it served, and to discourage those it assisted from becoming dependent on charity or the state.[32] The Mission's nurses investigated all requests for assistance and ensured that only those in the greatest need received nursing care from their organization. Those not qualifying for their assistance were referred elsewhere. At the 1906 annual meeting, reported a local newspaper, Scott herself spoke to this issue:

> One very cheering thing she mentioned in connection with her work was that those who were helped in this new country soon learned to help themselves. Scarcely five people who received relief two years ago were on her list now. . . . The mission simply 'helped lame dogs over stiles'. . . .

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[30]AM. The Mission papers, MG10, B9, Box VI. *Twenty-Fourth Annual Report*, (1928), 9; *Twenty-Sixth Annual Report*, (1930), 11.

[31]AM, The Mission papers. MG10, B9, Box VI, *Thirty-Seventh Annual Report*, (1941), 7.

[32]This phrase, with its strong associations with British Poor Laws, appears at regular intervals in the Mission's annual reports. See, for example, AM, The Mission papers, MG10, B9, Box VI. *First Annual Report*, (1905), 5; *Twenty-Eighth Annual Report*, (1932), 8.

those who would be always a burden are to be deported after two years.[33]

The Mission's working relationship with the medical community also reveals its philanthropic emphasis. It did not depend upon physician referrals to develop a clientele. Their work, amongst the victims of disease and poverty, was continually before them in numbers which needed no augmentation, and for which the cultivation of "friends" in the medical community created no benefit. Many of the Mission's patients did not have an attending physician because they could not afford to pay for his services. It appears that there was some initial confusion within the medical community about whether or not doctors could collect fees for services provided to indigent patients from the Mission. The minutes of September 9, 1905, record that Margaret Scott had received letters from several physicians inquiring about fees from the Mission. However, because the Mission's budget made no provision for such expenditures, it did not pay physicians' bills on behalf of the patients it served.[34] The Mission's surviving case files, which cover the period from 1908 to 1922, contain regular documentation that the nurses called on the services of medical residents and students from the General Hospital when attending physicians were not available or when the family did not have one. This was especially true for obstetrical cases.

The Mission was the recipient of considerable support from the medical community, however. Each annual report contained a long list of Winnipeg physicians

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[33]Unnamed newspaper, Feb. 1906. This clipping was pasted behind the minutes of the 1906 Annual Meeting.

[34]AM, The Mission papers. MG10, B9, Box IV, Minutes of September 9, 1905.

who had worked with the Mission's nurses during the course of the year. For the most part, this service was a donation of time with no expectation of remuneration other than that which might be provided by the city relief officer. At most annual meetings, local physicians spoke warmly about the contribution that the Mission made to the alleviation of the suffering of the sick poor.

On the other hand, the medical community depended upon the Mission for the training of medical students. In August of 1907, the Manitoba Medical College wrote to the Mission "with a view to securing clinical material for our college students in connection with their maternity course." They "respectfully" requested the Board that "students of the final year be called to cases of confinement conducted by the nurses of the Mission."[35] Uncertain how to respond to this request, the Board consulted two physician members of their Advisory Board, J. R. Jones and R. J. Blanchard. Both agreed that the plan would be acceptable as long the students did not handle complicated deliveries or deliveries requiring the use of forceps.[36] The rather desultory manner in which this request was handled by the Board reveals that strengthening the link with professional medicine was not a priority for the Mission. A hand written note at the bottom of McCalman and Davidson's letter states that the matter was deferred until there was a larger attendance of Board members at a meeting. A subsequent letter from

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[35]AM, The Mission papers, MG10, B9, Box I. Letter dated August 9, 1907 from D. H. McCalman and J. R. Davidson. In 1907, McCalman was professor of obstetrics at the Medical College. Carr & Beamish, *Manitoba Medicine*, 56.

[36]AM, The Mission papers, MG10, B9, Box I. Letter from J. R. Jones dated September 12, 1907.

McCalman, dated October 28, acknowledges that the Board had yet to make a decision on this matter, and yet another handwritten note at the bottom of this letter notes that the matter had been deferred for now.[37] The official final correspondence related to this issue was a letter dated November 5th, 1907 from the Winnipeg Medico Chirurgical Society which informed the Mission that "a resolution has been brought forward objecting to the proposed arrangement with the Margaret Scott Nursing Mission to give clinical obstetrical teaching to medical students."[38] Doubtless, some members of Winnipeg's medical community feared that a more formalised free obstetrical service for charity patients represented a potential threat to their livelihood.

Between 1905 and 1937, the working relationship between Winnipeg physicians and the Mission was very informal. This arrangement appeared to be satisfactory to both parties. The Mission did not threaten the income of the city's physicians, and its nurses appeared to be able to obtain medical orders and assistance when they needed them. From a philanthropic perspective, this state of affairs met the needs of the patients, fulfilled the mandate of the organization, and posed no threats to the prevailing social order.

In summary, the composition of the Mission's Board, its emphasis on faith and pious service, its standards for financial support, and its relationships with its clients and the medical community emphasize the philanthropic philosophy which inspired its founding and animated its work in Winnipeg. As time went on, however, its social

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[37]AM, The Mission papers, MG10, B9, Box I. Letter from D. H. McCalman dated October 28, 1907.

[38]AM, The Mission papers, MG10, B9, Box I,. Letter from C. H. Vrooman, Secretary Treasurer, dated November 5, 1907.

environment was increasingly dominated by the rhetoric of populism and collective rights. The Mission's capacity to survive in changed times can be attributed to the strategic alliances it forged with influential individuals, the social gospel movement and maternalists.

Shared Values and Strategic Alliances: The Mission's Links with the Social Gospel Movement and Maternalism

Throughout much of its existence, the Mission attracted the support of influential Winnipeg citizens. Members of its first Advisory Board included G. F. Stephens, W. F. Alloway, A. M. Nanton and William Robinson, all wealthy businessmen known for their financial support of worthy causes. The first Board of Management included, as well as the wives of Nanton and Robinson, the wives of J. H. Ashdown, J. Stewart Tupper, M. Bull, B. E. Haggart, and William Whyte.[39] The Mission also recruited the wives of prominent local clergy, such as Alice Matheson, wife of the Archbishop of Rupertsland, and Helen Gordon, wife of Rev. C. W. Gordon. Wives of politically active Winnipegers also found their places on the Board of Management. Over time, more ordinary middle-class women were recruited to the Board but the aura of wealth and prestige continued through the retention of members such as (by then) Lady Nanton, and the recruitment of other women from wealthy families.[40] These strategic business, religious, and political alliances ensured that the Mission's needs could be readily placed before those in a

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[39]AM. The Mission papers. MG10, B9, Box VI, *First Annual Report*, (1905), 2.

[40]For example, Gertrude Code, daughter of C. E. Drewry, was recruited to the Board in 1932. Mrs. Joseph Harris, recruited in 1935, fulfilled two needs; she was a nurse and the wife of a wealthy businessman.

position to act on them.

Even in an era when philanthropic ventures such as the Mission were regarded as both elitist and old fashioned, the long arm of the past reached out to ensure its survival. The Mission received several legacies between 1925 and 1930.[41] These were invested, and during the 1930s, the Board drew on the principal to compensate for revenue shortfalls created by a decrease in both government grants and charitable donations. These last gifts from the Mission's early supporters provided, in more than one instance, sufficient funds to tide it over during revenue shortfalls. The legacy of W. F. Alloway deserves particular note. He was a generous founding supporter of the Mission, providing most of the money required to purchase and enlarge the Mission's Home at 99 George St. At his death in 1930, he left his entire estate as the initial endowment to the Winnipeg Foundation.[42] The Mission maintained its link with Alloway by appointing Peter Lowe, General Manager of the Winnipeg Foundation, to its Advisory Board in 1931. In that same year, the Winnipeg Foundation began giving grants to the Mission. Until 1942, funding from the Winnipeg Foundation was exceeded only by that received from the city. No doubt Alloway's love of the Mission and his admiration for its founder played an important role in securing this financial support.

Maintaining personal relationships with influential and wealthy Winnipegers was one important element in the Mission's survival. Another was its ability to draw on the

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[41]Sir Augustus Nanton (d. 1925) left $5000 to the Mission. Lady Agnes Schultz (d. 1929) bequeathed $2000. Mr. J. H. Oldfield (d. 1930) left $5000.

[42]*Winnipeg Free Press*. Feb. 3, 1930.

energy and resources of other groups with similar agendas. Despite their primary emphasis on philanthropy, the Mission's Board formed a strategic alliance with proponents of the social gospel. The social gospel movement, a unique epoch in the history of Protestant Christianity, was at the height of its world-wide influence in the early twentieth century. The language of social salvation and the attainment of God's kingdom on earth united clergy, politicians, and ordinary citizens.[43] Winnipeg was at the centre of its Canadian expression.[44]

Both their church affiliations and their residence in Winnipeg ensured that members of the Mission's Board were aware of the theological and social debates generated by the social gospel movement.[45] The known church affiliations of the women who comprised the Mission's Board of Management were Congregationalist, Baptist, Methodist, Presbyterian, and Anglican. These denominations were also the most actively engaged in the social gospel movement in Western Canada.[46]

A large number of Board members were Anglican. It might be inferred that this would result in a more conservative approach to social reform.[47] However, two

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[43]Merkley, "The Vision of the Good Society in the Social Gospel," 138-156.

[44]Allen. *The Social Passion.*

[45]For a fuller discussion of the intellectual ferment generated by these developments, see the following: Allen, *The Social Passion*; Cook, *The Regenerators*; Dale, *In Pursuit of a Scientific Culture*; Gorrell, *The Age of Social Responsibility.*

[46]Allen, *The Social Passion*; Nancy Christie, "'In These Times of Democratic Rage and Delusion.'"

[47]Christie, "In These Times of Democratic Rage and Delusion." Christie identified the Anglican Church of Canada as the least radical proponent of the social gospel, stating

characteristics of the Mission ensured that its appeal extended beyond the Anglican Church. First, the Mission was organized as an inter-denominational agency.[48] This enabled it to attract support from all mainstream protestant churches, both in Winnipeg and in rural Manitoba.[49] Second, the evident piety of the Mission's approach to its work gained the approval of more radical social reformers, who spoke enthusiastically at annual meetings of its contributions to their efforts.[50] The support of the Rev. C. W. Gordon, a well known proponent of the social gospel, was especially important to the early success of the Mission.[51]

Common ground was forged between the philanthropic women of the Mission and proponents of the social gospel through a shared concern about the social consequences of Winnipeg's rapid growth at the turn of the century. Between 1901 and 1916, the population of Winnipeg grew from 42,000 to 163,000. The greatest percentage of this increase was due to immigration. By 1916, 48.2% of Winnipeg's population had been

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that its role as the establishment church in Canada made it more likely to re-interpret the social gospel message within the proper workings of Canadian society and to place reform initiatives within their existing corporate structures.

[48]AM, The Mission papers. MG10, B9, Box VI, *First Annual Report* (1905).

[49]The Mission's Annual reports regularly listed contributions from both rural and city congregations.

[50]Newspaper accounts in the early years of the Mission's existence regularly featured comments by clergymen speaking in support of the Mission. They placed a high value on the spiritual aspect of the Mission's work. See, for example, *Winnipeg Telegram*, May 26, 1904; *Winnipeg Free Press,* Oct. 31, 1910.

[51]As well as providing substantial financial support to the Mission until 1914, C. W. Gordon regularly spoke in support of the Mission at their Annual Meetings.

born in Canada, 29% in Britain, 4.2% in the United States, and 8.6% in non-English speaking countries. Percentages, however, do not tell the whole story. In 1916, 8.6% of Winnipeg's total population of 163,000 equalled 14,018 foreign-born immigrants from non-English speaking nations. In addition, some of those categorized as Canadian-born were the children of recently arrived immigrants.[52] Crowded into substandard housing in Winnipeg's North End, chronically underemployed, frequently unemployed, and beset by a myriad of social problems, Winnipeg's immigrant population was regarded with a combination of loathing and compassion by well established Anglo-Canadian fellow citizens. The perception that the Mission alleviated the suffering of recent immigrants who could not afford to pay for medical and nursing care ensured continued support from churches and social reformers such as C. W. Gordon.

The social gospel movement also provided the Mission with a link to maternalism, which espoused a particular interest in the improvement of the social conditions affecting mothers and children. Maternalism was rooted in the belief that biological differences between men and women translated into the need for social reform programs that protected the primacy of the male wage earner and valued the service that mothers performed for the state by raising healthy children.[53] Nancy Christie and Michael

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[52]This data was calculated from statistics included in Artibise, *Winnipeg*. Other sources which discuss Winnipeg's rapid growth during this era include: Artibise, "Divided City,"; Woodsworth, *Strangers Within Our Gates.*

[53]Because of their apparently limited focus on female emancipation, maternalists were often categorized as maternal feminists (as opposed to equal rights feminists). More recent scholarship, influenced by the work of Ladd-Taylor, argues that maternal feminists were not feminists at all. These historians refer to the early twentieth century women's movement based on biological differences as maternalism. However, as Koven and

Gauvreau argue that the after 1919, the social gospel movement continued to influence social policy by forming a strategic alliance with maternalists who were also advocating sweeping social reform. This alliance kept leadership in Canadian social reform firmly in the hands of the protestant Christian community until well into the 1930s.[54]

The link with maternalism is important because female philanthropists, like maternalists, exhibited a particular concern for the health of women and children, and founded community-based educational and social programs to assist them.[55] The Mission's interest in women and children motivated them to pioneer two important public health programs in Winnipeg. In 1910, using city funding, the Mission established Winnipeg's first child welfare program. Mission nurses visited mothers of newborn infants and, focussing on prevention, taught the basic principles of breast feeding, introduction of solid foods to the infant's diet, and general household hygiene.[56]

In 1911, a school based prevention program, the Little Nurses League, was

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Michel argue, it is important not to overlook or underestimate the contributions that maternalists made to the development of the welfare state. See, for example: Gordon, *Pitied But Not Entitled*; Koven and Michel, "Womanly Duties," 1077; Ladd-Taylor, *Mother-Work*, 3-11.

[54]Christie & Gauvreau. *A Full-Orbed Christianity.* The argument that 1919 marked the beginning of a decline in the energy and achievements of the social gospel is put forward by, amongst others, Allen, *The Social Passion.* and Cook, *The Regenerators.*

[55]Gerard, "Lady Bountiful;";Kidd, "Philanthropy and the 'Social History Paradigm;'" Kunze, "Poore and in Necessity;" Preston, "Lay Women and Philanthropy in Dublin, 1860-1880;" Prochaska, "Female Philanthropy and Domestic Service in Victorian England."

[56]AM. The Mission papers. MG10, B9, Box I. Letter from Mrs. B. Davidson (Estella Clark), Cartwright Manitoba. Educated in Scotland, she worked as a Child Hygiene nurse at the Mission from 1912-1916.

initiated in cooperation with the Winnipeg School Board.[57] Targeting young girls with younger siblings at home, this program also taught basic household hygiene and food preparation with a particular emphasis on the safe storage of milk and the health hazards posed by household flies. The program was hailed as an outstanding success.

One might argue that these achievements place the members of the Mission's Board in the ranks of the maternalists.[58] However, the evidence does not support this conclusion. The Mission's programs did not create cross-class alliances with the working class women they served.[59] The Board did not even initiate the discussions leading to the development of these programs. The child hygiene program was proposed by A. J. Douglas, who had evidently discussed it with Scott prior to writing a letter to the Board proposing the pilot project. The Little Nurses League was Scott's idea, and she had already secured the necessary funding and located a nurse with the appropriate knowledge and experience to implement the program prior to proposing it to the Board. If not for the initiative of these two individuals, the Board would have simply continued to provide bedside nursing care to the sick poor.

As it was, the innovative public health programs pioneered by the Mission were

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[57]AM. The Mission papers. MG10, B9, Box IV. Minutes of Sept. 11, 1911 anf June 10, 1912.

[58]Several review articles provide an excellent analysis of current scholarship on maternalism and, more generally, on the contribution of women to the development of the modern welfare state. These include: Howe, "Gender and the Welfare State;" Koven, "The Ambivalence of Agency;" Lewis, "Women's Agency, Maternalism and Welfare;" Moeller, "The State of Women's Welfare in European Welfare States."

[59]This was often a feature of maternalist reform efforts. See, for example, Flanagan, "Gender and Urban Political Reform."

soon transferred to other agencies. In 1913, the Little Nurses League program and the nurse in charge of its planning and implementation were transferred to Winnipeg School Division.[60] In 1914, the Mission transferred all child hygiene work within the city limits to the city's health department.[61] The suburban child hygiene program was transferred to the Provincial Department of Health in 1922.[62] The Mission's willingness to pilot these programs was consistent with their goals and values. However, their willingness to turn the programs over to other organizations once their efficacy was established provides substantial evidence that the Board had no political agenda and no desire to change the status quo in any significant way. Less conservative social reformers might have used the success of these programs to leverage continued financial support and to stake a claim for their continued presence in the political arena to attain broader social reform.[63]

Another important difference distinguished the philanthropic perspective of the Mission's Board from maternalism. Maternalists brought domestic skills and knowledge into the public sphere. In contrast to this "domesticity writ large," the Mission's Board engaged in "domesticity in duplicate." They managed two households; their own and the Mission's Home at 99 George St. The latter consumed an enormous amount of time and energy. Each month, the Board minutes duly noted the report of the Visiting Committee and its lengthy list of supplies needed, household repairs required, and linens to be

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[60]AM. The Mission papers. MG10, B9, Box IV. Minutes of May 12, 1913.

[61]AM. The Mission papers. MG10, B9, Box IV. Minutes of Sept. 14, 1914.

[62]AM. The Mission papers. MG10, B9, Box IV. Minutes of Feb. 12, 1922

[63]Flanagan, "Gender and Urban Reform,"; Hutching, "'Mothers of the World.'"

replaced. Arrangements for household laundry regularly fell through and had to be renegotiated. In addition, there were servants to be supervised and nurses to be cared for. Uniforms were in a constant state of disrepair, transportation needed to be arranged, and rules for conduct in the Home needed to be established and enforced. The Board maintained full control over all of these responsibilities, and only rarely was household management delegated to Mission employees. The constant financial constraints under which the Mission operated precluded the employment of a household manager. However, it is debatable whether the Board would have taken this step even if they could have afforded it. They took pride in the efficiency with which the home was run and the part they played in ensuring that household standards were maintained. "Your convenor paid a visit to the Mission," wrote Gertrude Code in 1937, "and came away feeling that if she could keep her house in such good order she would be a very happy woman."[64] So content was the Board with its domestic arrangements that 99 George St. remained the Mission's administrative centre and the nurses' residence for its entire existence.

Forging Links With the Emergent Welfare State

The congruency of values shared by philanthropy, the social gospel movement, and maternalism were important elements in assuring the long term survival of the Mission. Given the high level of social interaction amongst their proponents, it is easy to understand how mutually beneficial strategic alliances could be formed. However, another important relationship also sustained the Mission and ensured its survival. This was the congruence of the Mission's goals with those of the emerging modern welfare

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[64]AM. The Mission papers. MG10, B9, Box V. Minutes of May 10, 1937.

state. The Mission's founding occurred during the early stages of the development of Winnipeg's health care system, and its history parallels the initial stages of universal health care in Manitoba and Canada.[65]

The Mission enjoyed an enduring relationship with the Winnipeg General Hospital, the city's largest health care institution. It was the last and most successful product of a series of experiments by the Winnipeg General Hospital and its supporters to provide visiting nursing services to those unable to afford hospital care or private duty nursing. The 1897 WGH *Annual Report* provides this account of the hospital's first experiment with visiting nursing:

> In May last a representation was made to the Board by the City Health Officer that there are always cases of sickness in the City in which the patients are unable either to leave their homes to go to the Hospital or to engage proper nursing at home. . . . The Board thereupon decided to make the experiment of taking up this work of District Nursing in connection with the Hospital and in July one of the graduates of the School was appointed as a District Nurse.[66]

This arrangement continued until 1901, when the hospital discontinued funding for the position. However, collaboration between the Hospital and the Mission continued until the latter's closure of its visiting nursing program in 1942. The Hospital depended upon the Mission to reduce the number of admissions and lengths of stay of low income

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[65]A recent body of literature argues that the foundations of the modern welfare state lie in the late 19th century. See, for example, McCarthy, *Lady Bountiful Revisited*; Naylor, *Canadian Health Care and the State;* Sears, "Before the Welfare State." These accounts focus on the social origins of the welfare state, in contrast to literature which focuses more on economic and political events in the early 20th century.

[66]NAA WGH/HSC Archives, *Annual Report and Accounts*, (1897), 6.

patients.[67]

In turn, the Hospital provided the Mission with financial stability. Beginning in 1906, the Hospital's School of Nursing sent senior nursing students to the Mission for experience in district nursing.[68] At any given time, up to eight student nurses lived at 99 George St. and made home visits to the Mission's patients. This program was initiated by Annie Bond, Convener of the Mission's Nursing Committee, as a strategy to overcome difficulties the Mission was experiencing in attracting qualified district nurses. Although Bond actively recruited British educated nurses to overcome staffing shortages, she believed that the better solution was to incorporate district nursing into the School of Nursing's curriculum in the hope that its graduates would become committed to the work. This relationship was so highly valued by both parties that the Hospital's School of Nursing invited the Mission to participate in its Jubilee celebrations in 1938.[69] Therefore, throughout its history, the Mission had access to an important resource in the form of unpaid nursing labour. During the 1920s and 1930s, the number of student nurses working at the Mission was actually larger than the staff of fully qualified nurses. In contrast, its sister organization, the Winnipeg Branch of the Victorian Order of Nurses, had only one student at a time affiliate with them while employing a staff of nine

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[67]*Manitoba Free Press,* Nov. 12, 1904; *Winnipeg Telegram*, Nov 1, 1910. AM, The Mission papers, MG10, B9, Box VI. *Thirty-Second Annual Report*, (1936).

[68]AM, The Mission papers, MG10, B9, Box VI. *Thirty-Fourth Annual Report*, (1938), 9.

[69]AM. The Mission papers. MG10, B9, Box I. Letter from Annie Bond to Miss Wilson, Lady Superintendent of the Winnipeg General Hospital, June 13, 1906.

qualified nurses.[70] Supplementing paid nursing positions with unpaid student labour enabled the Mission to provide nursing care at a very low cost.

The Mission also enjoyed a close working relationship with the city's health department. It received direct grants from the city's operating budget throughout its history. In times of high unemployment, particularly during the Depression, additional funding was received from the city to enable the Mission to employ additional nurses.[71] Winnipeg's medical health officer, A. J. Douglas, was a member of the Mission's Advisory Board, and the Mayor and Chair of the city's Finance Committee were ex officio members. City funding enabled the Mission to maintain its policy of not soliciting donations from the public, and thus contributed to its longevity.

The Mission's relationship with the Provincial Department of Health was not as close, and the level of funding from this source never equalled that obtained from the city. However, the relationship with the provincial government was also cordial and mutually beneficial. For example, in 1918, the Mission agreed to a request from Elizabeth Russell, Director of Public Health Nursing, that three Provincial Welfare nurses be posted at the Mission for three weeks to learn about district nursing.[72]

The extent to which the Mission coordinated its work with that of other health

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[70]AM. The Mission papers. MG10, B9, Box I. Reports. 1939.

[71]The Mission declined further funding from the city's Unemployment Relief Committee in 1935, stating that "the Mission can take care of the need without the financial help you have been giving." Letter from Catherine Robinson, President The Mission to the Chairman of the Unemployment Relief Committee. Nov., 1935. AM. The Mission papers. MG10, B9, Box I, Correspondence.

[72]AM. The Mission Papers. MG10, B9, Box IV. Minutes of Jan. 14, 1918.

care agencies operating in Winnipeg underscores the link between its basic philosophy and those of the emerging health care system. Both the Mission and the emergent welfare state focussed primarily on the economic barriers to health. Sear's analysis of the foundations of the modern welfare state provides further confirmation of congruent ideologies within the management of the Mission and Winnipeg's emerging health care system.[73] Home visits by nurses placed a particular emphasis on the mother's role in the maintenance of family health, disregarding or at least minimizing the impact of environmental and social factors on health. Preserving and restoring the health of the poor, especially poor women and children, was viewed as an investment in the state and in the creation of healthy and self-sufficient citizens. Politicians and businessmen were quick to place an economic value on organized efforts to save the lives of Winnipeg's immigrant population. The *Manitoba Free Press*, in its coverage of the inaugural meeting of the Mission, reported that D. W. Bole, a Winnipeg MP, stated that "every good immigrant brought in was valued at $1000 to the state and that the lives already here were just as valuable to be preserved." At the same meeting, J. H. Ashdown, a prominent Winnipeg businessman, pointed out "the business prudence of such an investment (financial support of the Mission) for the betterment of the health of the poor."[74] For nearly forty years, this was the Mission's primary mandate.

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[73]Sears, "Before the Welfare State."

[74]*Manitoba Free Press,* May 27, 1904.

From Innovation to Stagnation: The Demise of Philanthropy and the End of the Mission

Ultimately, the Mission's increasingly old-fashioned approach to the provision of visiting nursing services made it impossible for the organization to retain even its original cherished mandate as the provider of charitable nursing services to the sick poor. Because of its failure to modify its organizational goals and guiding philosophy, the Mission literally gave away opportunities to expand its influence in Winnipeg's public health system and to tap into additional sources of revenue. In the early years of its existence, individuals regularly appeared at 99 George St. requesting relief. The Board moved quickly to discourage those seeking only financial assistance. Placards were placed both at the Coffee House and at the Mission which stated that no relief would be distributed from the Home.[75]

As well as turning away individuals who simply needed money, the Mission turned away organizations that offered potential new sources of revenue. In 1919, the Board turned down a proposal from the Metropolitan Life Insurance Co. to provide nursing care for their policy holders because this venture would involve caring for individuals and families who could afford to pay for their health care through insurance premiums.[76] It turned down another request from the same company in 1933, this time because the policy holders identified by the company resided in Transcona, which was

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[75]AM. The Mission papers. MG10, B9, Box IV. Minutes of Jan. 13, 1908.

[76]AM. The Mission papers. MG10, B9, Box IV. Minutes of April 14, 1919.

not within the Mission's self-defined catchment area.[77] In 1912, it turned down a request from the City of St. James to provide a district nursing service and referred them to the VON.[78] Indeed, from the time the VON established a branch in Winnipeg in 1905, the Mission referred all individuals who could pay for bedside nursing services to them, retaining for itself only those who could not.[79] Although its commitment to care for only those in greatest need won for the Mission the admiration and respect of the community, it was a strategy which could not be sustained financially.

In 1937, it appeared that the Mission came close to losing the admiration and respect of the community which had for so long supported its work. The Assistant Superintendent of Nursing abruptly resigned, and in a personal visit to the Chair of the Nursing Committee, complained that conditions at the Mission were "intolerable."[80] Her resignation was followed in short order by the resignation of two board members, Mrs. Gordon Chown and Mrs. Spurgeon Campbell, both wives of prominent Winnipeg physicians. Four nurses and the Board's President, Vice-President and Secretary also resigned. In addition, the Board requested that the Superintendent, Miss West, submit her

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[77]AM. The Mission papers. MG10, B9, Box V. Minutes of Nov. 13, 1933.

[78]AM. The Mission papers. MG10, B9, Box IV. Minutes of October 14, 1912.

[79]AM, The Mission papers, MG10, B9, Box IV, Minutes of May 9, 1910; Box I, letter from Mrs. A. Code to Dr. MacCharles, President of the M.M.A, dated March 18, 1938. This policy is first evident in 1910 and continued until the VON took over the Mission's caseload on May 1, 1942.

[80]AM, The Mission papers. MG10, B9, Box V. Minutes of January 11, 1937.

resignation.[81]

The exact nature of the problems precipitating this crisis is not clear. Cryptic comments regarding students making unsupervised home visits, the provision of nursing care without doctor's orders, and a general lack of discipline and respect on the part of students (and perhaps employees) are all that survive in the written record.[82] However, it seems certain that there was considerable dissatisfaction about the quality of nursing care provided by the Mission and a significant erosion of support from the medical community. The Board moved quickly to remedy the damage created by the medical community's loss of confidence in the Mission's work. A Medical Advisory Committee was formed and members of the medical community were approached to serve as members.[83] In a letter to potential Medical Advisory Committee members, Gertrude Code, Board President, outlined the purpose of this committee:

> They [the Board] earnestly wish to work in closer co-operation with the Medical Profession. With a view to strengthening their nursing Service, it was recommended:- 'That a Medical Advisory Board be established, who,

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[81]AM, The Mission papers. MG10, B9. Box V. Minutes of February 8, 1937, February 26, 1937, March 5, 1937 and March 8, 1937.

[82]AM, The Mission papers. MG10, Box IX. Minutes of the Special Committee meeting, Jan 22, 1937. Comments to this effect are pencilled in the margin of the typed minutes. The Mission Board of Management appointed a Special Investigation Committee, chaired by Gertrude Hall, Executive Secretary of the Manitoba Association of Registered Nurses [MARN]. However, a copy of their report is not in the Mission papers. It also could not be located in the archives of the MARN (now the College of Registered Nurses of Manitoba).

[83]AM, The Mission papers. MG10, B9, Box VI. *The Twenty-third Annual Report* (1937). Members of the newly formed Medical Advisory Board are listed on page 4. Dr. A. J. Douglas, Medical Officer of Health for the City of Winnipeg, continued to serve on the original Advisory Board.

> in co-operation with the Nursing committee, could give valuable help and in particular their advice should be sought in connection with standing orders and treatments under the Nurses' Manual. . . . We hope it is not asking too much, but as you know we train pupil nurses and we are aiming to improve this training . . . The Board has a strong Nursing Committee who have worked very hard in trying to bring the Mission Service up to date.[84]

It is also clear that the Mission had lost touch with current standards for nursing education and for the qualifications required of nurses working in the community. Five years earlier, in 1932, George Weir had published a report on nursing education in Canada in which he had been very critical of the apprenticeship educational model for nursing. He was particularly opposed to the practice of using student nurses as an unpaid labour force.[85] As well as putting the Mission's patients at risk by using inexperienced and unsupervised student nurses to provide bedside nursing care, the Mission had also not kept abreast of the increasingly higher professional qualifications and standards of practice required of nurses working in community settings. Annie Bond had raised this issue with the Board in 1933, stating that in future, only nurses with good post graduate work in public health should be employed by the Mission. However, the low salaries paid to the Mission's nurses made it difficult for them to attract and retain more qualified candidates to their nursing staff.[86] The Mission's success in providing a low cost nursing service, which had been predicated on the use of under-skilled student and graduate

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[84]AM, The Mission papers. MG10, B9, Box I. Letter from Mrs. A. Code to Dr. Anna E. Wilson dated June 21st, 1937.

[85]Weir, *Survey of Nursing Education in Canada.*

[86]AM. The Mission papers, MG10, B9, Box V. Minutes of Sept 11, 1933.

nurses, became less acceptable to health care professionals and the public as time went on.[87] Initiatives to modernize its nursing program came too late and the cost of modernization was too high.[88] Increasing the number of qualified graduate nurses and decreasing the number of student affiliated with the Mission could not be implemented within the financial constraints being experienced during the very difficult years of the Great Depression.

The Mission discontinued its district nursing program in 1942 following the recommendation of an independent consultant appointed by the Provincial Government to reorganize its community based health and social welfare programs.[89] One might have expected these dedicated women to resist this outcome. However, they did not. The Board acknowledged that, because of financial constraints, it could no longer provide the standard of nursing care required by the community. Because other organizations, such as the VON, were strategically positioned to continue the work it had pioneered, the women of the Mission's Board were content to leave the field in favour of a more publicly funded, publicly accountable system. Their work, far from becoming irrelevant, had been recognized as being an integral part of the state's responsibility to its citizens.

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[87]This criticism was also contained in the Buck Report. See: Buck, *Public Health Activities in Winnipeg*, 27-30.

[88]Three changes in the governance of the Mission occurred in 1937. The Mission appointed a representative from MARN to the Board of Management. It also created a Medical Advisory Board and recruited physicians specializing in pediatrics, obstetrics and internal medicine as members. Finally, it reorganized the Nursing Committee and required that the chair and the majority of its members be graduate nurses. AM. The Mission papers. MG10, B9. Box V. Minutes of Feb 8, 1937.

[89]Buck, *Public Health in Manitoba*, 30.

It is all too easy to dismiss the members of the Mission's Board of Management as wealthy, pious, and increasingly old fashioned matrons with soft hearts and time on their hands. However, this does neither them nor the historiography of the Canadian health care system justice. The motivation to work for the benefit of others is rooted in more than just personal growth. It is difficult to imagine that self-gratification alone would sustain the motivation to voluntarily provide nursing care to Winnipeg's poorest citizens during forty of the city's most turbulent years. A more long term and, arguably, a more sustaining motivation was the sincere desire to create a better society.

In seizing the opportunity set before them in 1904, the women of the Mission's Board exploited public opinion and goaded the consciences of Winnipeg's political and business leaders. They may have eschewed public solicitation of funds from individual citizens, but they had no qualms about demanding financial support from business and government. At the Mission's first organizational meeting, delegations were organized to visit representatives of all three levels of government and secure ongoing funding.[90] Subsequent minutes document many instances where the Board actively solicited increased funding from government, or protested reductions in revenues from this source.[91] Only in the 1930s, when government funding reductions were a regular occurrence, did it appear that the Board of Management was willing to acquiesce in

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[90]AM. The Mission papers, MG10, B9, Box. IV. Minutes of May 12, 1904.

[91]See, for example, AM, The Mission papers, MG10, B9, Box IV. Minutes of May 10, 1915; Box I, Correspondence. A series of letters between D.W. Bole, MP and Louise Minty, Secretary of the Mission's Board reveal that the Mission was pressing the Federal Government to fund a visiting nursing service despite the fact that Government guidelines did not allow for this type of expenditure.

reductions of government grants.[92]

The Mission placed the needs of Winnipeg's poor and immigrant population on the public agenda. Its correspondence reveals a knowledge of the health and social problems of Winnipeg's immigrant population which clearly exceeded that of the governments responsible for their care. Louise Minty's letter to the Superintendent of Immigration is a study in the frustration experienced while collaborating with ill-informed and inflexible civil servants. In the process of protesting the Federal Government's decision to reimburse the Mission for only six of the twenty-three immigrant families it had cared for over the previous three months, Minty offered the Superintendent a compelling lesson on the unreliability of ships' manifests, the inability of the hospitals to care for the large number of poor people who were ill, the complexity of providing service to a population speaking a myriad of languages (none of which was likely to be English), and the unfairness of the Federal government's policy to accept financial responsibility for the health care of new immigrants for only the first year of their residence in Canada.[93] The Board also secured private sector funding from the CPR for several years on the strength of arguments that the railway, having brought in the immigrants, and having located many of their employees in the poorly planned and

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[92]AM. The Mission papers. MG10, B9, Box. V. Minutes of Sept. 2, 1932. The minutes document that the Board, although disappointed with the decrease in provincial funding, decided to accept the funds received and hope that the reduction was for one year only. It wasn't.

[93]AM. The Mission papers. MG10, B9, Box I. Undated memorandum (c.1906) from Louise Minty, Secretary of the Mission's Board of Management to the Superintendent of Immigration.

unsanitary Weston district, should take some responsibility for the nursing care that the Mission provided to these populations.[94]

During the Mission's existence, members of the Board brought other health related issues to the attention of Winnipegers and supported other reform initiatives. For example, their experience with the obstetrical services available to poor women made the issue of lay midwifery a priority for the Board, and one for which they were willing to take political action. Annie Bond, a highly decorated British trained nurse and a tireless advocate of improved health care for women and children, took a leading role in bringing this issue before the Mission's Board:[95]

> Mrs. Bond reported a representation of the Margaret Scott Mission on the Committee on the question of midwifery; nothing had been done and she felt the problem was a very serious one, and should be dealt with as early as possible. Moved by Mrs. Riley, seconded by Mrs. Drewry that a letter be forwarded to the convenor of the committee, signed by Mrs. Scott & Mrs. Bond. Carried.[96]

What the experience of the Mission reveals is that conservatism may restrict the range of solutions available to a group of reformers, but it does not necessarily restrict their vision or diminish their motivation to redress the injustices of society. Non-political and non-confrontational approaches to the alleviation of suffering still require the willingness to engage with, and to some extent, oppose the existing social structure. The experience of the Mission's female Board of Management is a concrete example of this

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[94]AM. The Mission papers. MG10, B9, Box VI. *Second Annual Report*, (1906).

[95]Leah, "Metro Street Names"; Leah, "Pages from the Past"; Medovy, *A Vision Fulfilled*; Robertson, "Nurse's Medals Restored."

[96]AM. The Mission papers. MG10, B9, Box IV. Minutes of May 13, 1918.

reality. Their work put the needs of the poor, especially poor women and children, before the public conscience. Although not radical enough to advocate drastic measures to remedy these inequalities, they provided others with the information and the inspiration to do so. They formed an important ideological and generational bridge between the individualistic and episodic philanthropy of the nineteenth century and the organized system of rights and benefits embedded in the structures of the late twentieth century Canadian welfare state. And, for all its faults and shortcomings, few Canadians would deny the importance of that legacy.

Conclusion

The Margaret Scott Nursing Mission, founded in 1904, was the first visiting nursing organization in Winnipeg. The Mission's presence in Winnipeg enabled the transfer of city's visiting nurses from the masculine control of hospital and public health officials to the feminine control of women philanthropists. The Mission's all female Board, drawn from the ranks of Winnipeg's most elite and influential citizens, embraced the philanthropic ideals of Margaret Scott, the Mission's inspirational leader. For nearly forty years, these women provided the financial and managerial resources necessary for the delivery of bedside nursing services to Winnipeg's sick poor. During the Mission's existence, it pioneered two fundamental public health nursing programs; the Child Hygiene program and the Little Nurses League. Both programs used educational strategies and face-to-face interactions with the recipients of these services rather than the remote, regulatory strategies favoured by male public health officials. Women and children, rather than the environment and business interests were the targets of these

interventions. Both programs were ultimately drawn into the publicly funded public health system, transforming both the masculine world of regulation and the feminine world of providing care.

Chapter 5

The Professionalization of Visiting Nursing: The Case of the Winnipeg Branch of the Victorian Order of Nurses for Canada, 1905-1941

Introduction

In 1905, the Winnipeg Branch of the Victorian Order of Nurses for Canada established a visiting nursing program in Winnipeg. Unlike its sister organization, the Margaret Scott Nursing Mission, the VON provided only limited service to charity patients. This chapter explores this and other differences between the VON and the Mission. It examines how the VON and the Mission differentiated themselves and how they divided the work between the two organizations. The business-like administrative practices of the VON are contrasted with the more traditional domestic arrangements of the Mission. The VON's professional relationships with physicians and its attitudes regarding educational standards for visiting nurses are contrasted with the more old-fashioned standards of the Mission. Finally, the financial records of both organizations are analysed to determine how differing philosophies about charity and charity organizations shaped their revenues and their financial stability.

Because it provided primarily non-charitable visiting nursing services in Winnipeg, the VON was obligated to organize and account for its work in a more rigorous manner than was the Mission. It was also forced into much closer cooperation with male-dominated organizations such as the Metropolitan Life Insurance Company and the Federated Budget Board of Winnipeg.[1] Although initial interactions with these

[1]The Federated Budge Board of Winnipeg was an outgrowth of Winnipeg's Central Council of Social Agencies. It was organized to reduce the independent door-to-

organizations began in response to concerns expressed about the lack of coordination of social and health services, ultimately male politicians, bureaucrats, and businessmen began to exert control over both the VON's fundraising activities and their visiting nursing programs. As well, Winnipeg physicians, concerned that the VON constituted a threat to their livelihoods, also deployed strategies to regulate the nature and scope of the VON nurses' practice in the community. All of these developments ultimately resulted in a significant loss in autonomy for these female-led nursing organizations and an accompanying loss in the autonomy of the nurses that they employed.

The Winnipeg Branch of the Victorian Order of Nurses for Canada

The Victorian Order of Nurses for Canada was founded in 1897 to provide skilled nursing care in the home and to support the development of small cottage hospitals in rural and remote areas of the country. It was in connection with the Cottage Hospital Scheme that the VON first established a presence in Winnipeg. In April of 1901, Mrs. Daniel (later Lady) McMillan, wife of Manitoba's Lieutenant-Governor called a meeting at Government House "for the purpose of considering the advisability of establishing Cottage Hospitals in the outlying districts, to be in connection with the Victorian Order of Nurses and to assume the form of a Memorial to our Late Beloved Queen."[2] The twenty-six women who attended the meeting represented Winnipeg's social and political elite,

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door fund raising efforts conducted by many of Winnipeg's charitable agencies. The organization continues to this day under the name of The United Way. For a fuller discussion of the early development of the Federated Budget Board, see pages 203 to 205 of this chapter.

[2]VON, Manitoba Branch. Minutes of April 9, 1901.

including the wives of provincial and federal politicians, lawyers, clergymen, businessmen and physicians. Despite the enthusiasm with which this proposal was greeted, the nature of the task set before them was not completely apparent. The first executive of the Winnipeg Local Association of the Lady Minto Cottage Hospital Fund spent the next 2 ½ years attempting to clarify its working relationship with the Central Board in Ottawa. It was not until November 3, 1903 that Lady McMillan set before the Executive a proposal that the Winnipeg Association should assist with the furnishing of the Swan River Cottage Hospital.[3] The process by which this particular facility was selected is not documented in the Minutes, but given the fact that the Local Association tended to defer to or consult with the Central Board on most matters, it is reasonably certain that the selection of Swan River occurred in Ottawa. Between 1903 and 1905, the fledgling organization's principal focus was the furnishing and provisioning of the Swan River facility. This project ended as abruptly as it had begun. On April 12, 1905, a letter from Ottawa indicated that Central Board favoured the establishment of a Local Branch of the VON in Winnipeg to supply district nurses for the entire west.[4] The Swan River Hospital is never again mentioned in minutes of the Winnipeg Branch, although it continued to be aided by or affiliated with the VON until 1921.[5]

The Central Board's proposal that the Winnipeg Association should consider establishing district nursing services also seemed to catch the Local Board off guard. The

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[3]VON, Manitoba Branch. Minutes of November 3, 1903.

[4]VON, Manitoba Branch. Minutes of April 12, 1905.

[5]Gibbon, *The Victorian Order of Nurses for Canada,* 69.

Margaret Scott Nursing Mission, founded in May 1904, already provided visiting nursing services in Winnipeg. The Local Association's first response to the letter, therefore, was to create a delegation of two members to "obtain information relative to the scope of the Margaret Scott Nursing home and see if it would be feasible to form such an order without interfering in any way with it or other institutions of a similar character."[6] At the subsequent Board meeting, a definite decision was further delayed until Margaret Allen, Chief Superintendent of the VON, could visit Winnipeg.[7] On October 11, 1905, after an address from Allen, the Board voted to employ a district nurse in Winnipeg for one year.[8] In late December of 1905, the Winnipeg Local Association's first district nurse, Miss McCullough, arrived by train from Ottawa, was introduced to several local physicians, and began her work.[9] The experiment was so successful that a second nurse was added to the staff in the fall of 1906. In December of 1907, the Board formally changed its name to the Winnipeg Branch of the Victorian Order of Nurses for Canada.[10]

From the inception of the VON's visiting nursing service in Winnipeg, one of the major challenges facing both it and the Mission was how they might distinguish (and

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[6]VON, Manitoba Branch. Minutes of April 12, 1905.

[7]VON, Manitoba Branch. Minutes of September 27, 1905.

[8]VON, Manitoba Branch. Minutes of October 11, 1905.

[9]VON, Manitoba Branch. Minutes of January 10, 1906.

[10]VON, Manitoba Branch. Minutes October 10, 1907 and December 11, 1907. The tenure of the second nurse was exceedingly short. She was hired at some point shortly after the October 10th Board meeting and submitted her resignation at the December 12th Board meeting.

perhaps distance) themselves from one another. Unlike the United States, where the majority of visiting nursing associations were local entities gathered together by a national association, the VON was *the* Canadian visiting association. In most cities, the VON provided nursing services to all who required them; full pay, part pay and charity patients alike. The only known exceptions were in Ontario, where the St. Elizabeth Visiting Nurses Association provided care to Catholic patients in several cities, La Société des Infirmières Visiteuses de Montréal which provided services to the French speaking population of that city, and the Lethbridge Nursing Mission, which provided nursing services in a community where the VON had yet to gain a foothold.[11]

Winnipeg was different. It was the only city in which the VON had to differentiate itself from another visiting nursing organization on the basis of the patient's ability to pay. It was also a city which held in considerable esteem Margaret Scott herself and the Mission founded to assist her work. The challenge for the VON was to establish its own identity and constituency, and to create a space within which it, too, could participate in the city's emerging public health system.

From the Domestic to the Public Sphere: The Organizational Culture of the VON

In contrast with the Mission, the VON developed an organizational culture that enabled it to adapt to changing social beliefs about the meaning of charity, the relationship between organized medicine and nursing, and the professional practice of visiting nurses. To a great extent, the Local Branch's ability to respond to these external

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[11]Emory, *Public Health Nursing in Canada,* 27; Richardson, "Women's Enterprise,"105-30.

forces was a product of its close working relationship with the Central Board and its Chief Superintendents, who had regular contact with both the Board and the nurses it employed. In addition, new Local Superintendents and visiting nurses were often recruited from other Branches across the country, bringing with them new ideas and approaches to the practice of visiting nursing. These factors prevented the Board from relying on only a local frame of reference in developing its business practices, its relationship with local physicians, and its adherence to changing national standards for nurses employed by public health and visiting nursing agencies.

Unlike the Scott Mission, which purchased a "Home" on George St. soon after its formation, the VON had a more modest beginning. When their first visiting nurse was hired in 1905, the VON rented an apartment which served both as the nurse's home and the Local Branch's administrative headquarters.[12] The Board continued its custom, established in 1901, of holding the majority of its meetings at Government House. In 1910, the VON purchased a house at 145 Sherbrook St.[13] Like the Mission, this building served as a residence for the nurses and the administrative headquarters of the organizations. Board meetings were moved to this location soon after. However, their Annual Meetings, hosted by the wife of the incumbent Lieutenant-Governor, continued to be held at Government House.[14]

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[12]VON, Manitoba Branch. Minutes of December 13, 1905.

[13]VON, Winnipeg Branch. Minutes of September 14, 1910.

[14]The Minutes record that the first Board meeting at 145 Sherbrook was held on November 9, 1910. VON, Winnipeg Branch. Minutes of November 9, 1910.

During the period when the VON had its headquarters at 145 Sherbrook St., the Board's domestic duties were similar to those carried out by the Board of the Scott Mission. However, there were subtle differences in the degree to which these two organizations focussed on the domestic aspects of their work. The VON's Board was more likely to delegate the day to day domestic arrangements to its Local Superintendent. In fact, amongst the many other responsibilities, both domestic and professional, delegated to her was arranging for a vegetable garden to be ploughed and maintained in the back yard.[15] The Board also relieved itself of all responsibilities regarding the uniforms worn by the nurses by adopting the uniform prescribed by the Central Board in Ottawa, providing the nurses with a uniform allowance, and delegating to them the responsibility for purchasing and maintaining their uniforms.[16]

The VON only operated out of domestic space for the first seventeen years of its existence. In 1922, it moved out of its house on Sherbrook St. in favour of a more central location in downtown Winnipeg. After a brief period of time in a suite of offices in the Birks Building, it established its headquarters in the Medical Arts Building.[17] The nurses were left to make their own domestic arrangements. The impetus for the transition from

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[15]VON, Winnipeg Branch. Minutes of April 12, 1912.

[16]VON, Winnipeg Branch. Minutes of November 15, 1916. At this meeting, the nurses were given an allowance of $5.00 a month for uniforms. In 1921, this policy was changed on the advice of Charlotte Hanington, Chief Superintendent of the VON, who told that Winnipeg Board that the nurses should buy their uniforms out of their own salary. Minutes of October 15, 1921.

[17]VON, Winnipeg Branch. Minutes of October 4; *Twenty-third Annual Report,* (1924) 7.

domestic to business space was the organizations's dramatic expansion in 1920, when its staff increased from eight to fifteen nurses. Accommodations at 145 Sherbrook St. were extremely crowded. As well, the Local Superintendent, Annah Prichard, believed that greater efficiencies could be attained if the headquarters of the organizations were centrally located.[18] The Board was also aware that shedding the responsibility for the nurses' off-duty needs created greater administrative efficiency:

> Your district superintendent, Miss Prichard, being thus relieved of the worries of housekeeping, has had more time to devote to the essential work of the Order for which she is pre-eminently suited, viz., supervision of bed-side nursing, educational work and prenatal care and advice.[19]

The VON also adopted a professional working relationship with Winnipeg's medical community much earlier than did the Scott Mission. In response to a request by the Board, the Winnipeg Medical Society named its first advisory committee for the VON in 1923.[20] Likewise, standing medical orders, a 1937 innovation for the Mission, had been discussed by the VON as early as 1929.[21] Subsequent VON Board minutes document the development of standing orders for prenatal care given by the VON nurses, and their circulation to the Medical Advisory Committee and the general medical community for approval.[22]

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[18]VON, Winnipeg Branch. Minutes of December 21, 1921.

[19]VON, Winnipeg Branch. *Twenty-first Annual Report,* (1922), 6.

[20]VON, Winnipeg Branch. Minutes of March 21, 1923.

[21]VON, Winnipeg Branch. Minutes of February 11, 1929.

[22]VON, Winnipeg Branch. Minutes of January 20, 1932 and March 17, 1933.

Part of the reason for the VON's earlier adoption of a visiting nursing service explicitly organized under the supervision of the medical community had to do with the VON's greater need for the support of local physicians. It depended on physician referrals to stay in business. The capacity of the medical community to thwart the ambitions of the VON at both the local and national level was well known. In 1897, the vociferous objections of physicians had nearly prevented the formation of the Order in the first place.[23] The Winnipeg Medical Society, despite its distance from Ottawa, had participated fully in the 1897 debate, weighing in on the side of its colleagues in Ontario and the Maritimes.[24] Its continued suspicion of the VON's motives were well known within the Canadian nursing community. In 1906, the *Canadian Nurse* reported, with evident satisfaction, that the problem seemed to have been resolved. It reported:

> Miss McCulloch of Ottawa has recently arrived in Winnipeg, being the pioneer nurse of the Victorian Order, to "break ground" in the city. Until the present time there has been a decided antipathy to having the Victorian Order open a field of work in the city, but with the coming of Miss McCulloch all this is changed. She finds her time fully occupied.[25]

However, the medical community's ongoing interest in regulating the practice of VON nurses had to do with more than just their belief that these women might provide substandard care or become an alternative to the physician for those seeking health care. It also had to do with regular (allopathic) medicine's ongoing efforts to stop any attempt

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[23]Shakleton, *Ishbel and the Empire,* 231-241; Gibbon, *The Victorian Order of Nurses for Canada,* 1-26; Penney, *A Century of Caring,* 19-26.

[24] Gibbon, *The Victorian Order of Nurses for Canada,* 11; Penney, *A Century of Caring*, 20.

[25]*The Canadian Nurse,* 2, no. 1 (1906): 56.

on the part of the VON or any other nursing group to provide midwifery services to impoverished patients or to those living at some distance from the services of a physician.[26]

The VON's dependence on the support of the medical community was regularly emphasized at Board meetings. In 1928, for example, the Central Board's Western Superintendent stated that: "the doctor's say-so must be taken without question . . . we are really an Auxiliary to the Medical Profession and must cooperate with them."[27] The VON made frequent public statements to the effect that their nurses would only visit families attended by a regular physician. This policy was couched in general terms in early annual reports, which dwelt on the close working relationship between physicians and VON nurses and the fact that the nurses attended on "medical cases to which they are called by the physicians of the city."[28] But, by 1923, the exclusive call on the services of the VON nurse by regular physicians was formalized in a policy which stated that "the VO[N] should not nurse for irregular practitioners."[29]

Local physicians were more likely to be critical of the work of VON nurses and to make their protests known to the VON Board. In 1932, for example, Dr. Hart, president

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[26]There is an extensive literature on professional medicine's campaign to eliminate midwifery in Canada, and of the nursing profession's tacit support of these efforts. See, for example: Arnup, Lévesque, and Pierson, eds. *Delivering Motherhood*; Kinnear, *Insubordination,* 58-59; Penney, *A Century of Caring,* 20-22, 50-53, 59; Richardson, 'Political Women, Professional Nurses".

[27]VON, Winnipeg Branch. Minutes of October 17, 1928.

[28]VON, Winnipeg Branch. *The Fourteenth Annual Report 1914-15,* (1915), 6.

[29]VON, Winnipeg Branch. Minutes of March 27, 1923.

of the Winnipeg Medical Society, met with the VON Board and Medical Advisory Committee to state that nurses should not make prenatal visits to families unless this intervention was "sanctioned" by the attending physician. This request was duly drafted as policy by the VON Board.[30] In 1935, a local physician complained to the Board that a VON nurse working at a Well Baby Conference had changed an infant's feeding formula without his permission. This complaint necessitated consultation with the Board's Medical Advisory Committee and with Dr. F. W. Jackson, Deputy Minister of Health for the provincial government. In this case, the nurse was exonerated because she had followed the instructions provided in a pamphlet prepared by the provincial health department. The Medical Advisory Committee, in taking this stand, stated that: "The Victorian Order Nurse should be permitted to pass on and interpret this information until such time, if ever, recognized medicine is prepared to combat such official publicity."[31] At no point was any consideration given to consulting the nurse's professional association for advice.

The Scott Mission and the VON also differed in the extent to which they responded to changing standards of nursing education and practice. Initially, the Mission set the standard for visiting nursing practice in Winnipeg. When the VON began to consider opening a Training School in Winnipeg, observational experiences with the

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[30]VON, Winnipeg Branch, Executive Minutes of January 20, 1932.

[31]VON, Winnipeg Branch, Executive Minutes of December 17, 1935, January 22, 1936, Board Minutes of January 22, 1936, February 19, 1936.

Mission were included in the students' proposed field experience.[32] During the severe nursing shortage of 1919, the Central Board was willing to hire any Winnipeg General Hospital graduate who had completed an assignment with the Mission without requiring any further "post graduate" (post diploma) preparation.[33]

By the 1920s, however, the Mission was already losing its position as the local leader in the training of visiting nurses. The VON opened its own Training School in Winnipeg in 1920, and required that all nurses appointed to their staff complete this course of studies.[34] In 1921, after the introduction of public health nursing courses in five Canadian universities, VON Training Schools across the country were closed and diploma-prepared nurses were encouraged to enroll in university certificate programs prior to seeking employment with the VON.[35] The Winnipeg Branch began to actively debate the relative merits of university training for public health nursing in 1924.[36] Although urged by Elizabeth Smellie, the VON's Chief Superintendent, to encourage suitable candidates to apply for VON scholarships in support of university courses in

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[32]VON, Winnipeg Branch. Minutes of December 18, 1918 and Feb 19, 1919 (year incorrectly dated as 1918 in the minute book). The practice of having VON nurses affiliate with the Margaret Scott Nursing Mission continued even after the training school closed. In 1926, this option was discussed and approved in a meeting between Elizabeth Smellie, Chief Superintendent of the VON and the Board Executive of the Winnipeg Branch. Minutes of July 11, 1926.

[33]VON, Winnipeg Branch. Minutes of March 14, 1919.

[34]VON, Winnipeg Branch. *The Nineteenth Annual Report* , 6.

[35]Penney, *A Century of Caring,* 57; Mansell, *Forging the Future*, 57-58; VON, Winnipeg Branch. *The Twentieth Annual Report* , 5.

[36]VON, Winnipeg Branch. Minutes of April 22, 1924.

public health nursing, the Board had reservations about this development. The minutes of September 17, 1924 record the discussion between their Local Superintendent, Miss Prichard, and the Board:

> Miss Prichard gave an account of the qualifications of the experienced district nurse as compared with those of the university trained worker & said that the former feel that these latter are trying to usurp their place. Miss Prichard says this is hardly fair as they have had no practical experience. Mrs. Brown assured Miss Prichard that the attitude of the Board was in entire sympathy with her ideas in regard to the experiences district nurse & authorised her to say so at the Ottawa conference.[37]

Smellie, however, persisted in her insistence that university training in public health was the new educational standard for VON nurses. In 1925, she informed Winnipeg's Board that even "old nurses with experience" were enrolling in university courses to "bring themselves up to the new standard."[38] In 1926, the Board minutes record that Miss Manson had resigned her position with the VON to accept a $1000.00 national scholarship in support of university studies.[39] In 1927, a nurse with several years experience with the VON, but no formal post-diploma studies in public health nursing, refused the Board's offer to appoint her as Local Superintendent "on account of the attitude which Ottawa has taken toward her & her qualifications."[40] Eventually, she was persuaded to accept a temporary appointment as Local Superintendent, but she resigned

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[37]VON, Winnipeg Branch. Minutes of September 17, 1924.

[38]VON, Winnipeg Branch. Minutes of April 25, 1925.

[39]VON, Winnipeg Branch. Minutes of September 15, 1926.

[40]VON, Winnipeg Branch. Minutes of Executive Meeting of October 17, 1927.

from the Winnipeg Branch the following year.[41] By 1933, the Central Board recommended that all nurses employed by the VON should have post diploma training in public health.[42] As baccalaureate preparation for Canadian nurses became available, the educational standards for employment with the VON became even higher. In 1935, the Winnipeg Branch hired its first baccalaureate prepared nurse.[43] By 1942, it was actively implementing the Central Board's policy that nurses without post diploma preparation in public health could only be employed for a period of two years and should not be eligible for pay increments during that time. Although this policy was difficult to enforce during the nursing shortage of the Second World War, by 1946 the VON dismissed nurses who refused to enroll in post-diploma public health courses.[44] In contrast, in 1937, none of the five field nurses employed by the Scott Mission had completed a twelve month diploma in public health nursing. Four had completed shorter courses of study. One had no post-diploma qualifications at all.[45]

Nursing student affiliations with the VON were also handled very differently than those at the Mission. Winnipeg General Hospital nursing students did not begin to affiliate with the VON until 1931, although the Hospital had approached the VON several

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[41]VON, Winnipeg Branch. Minutes of November 16, 1927 and May 16, 1928.

[42]VON, Winnipeg Branch. Minutes of March 17, 1933.

[43]VON, Winnipeg Branch. Minutes of September 18, 1935.

[44]VON, Winnipeg Branch. Minutes of March 25, 1942; Minutes of Executive meeting of March 2, 1943; Minutes of October 10, 1945, September 11, 1946, October 9, 1946.

[45]Buck, *Public Health Activities in Winnipeg*, 8.

years earlier regarding visiting nursing experiences for nursing students.[46] Unlike the Mission, where students were allowed to make independent home visits, students affiliated with the VON were only allowed to observe qualified nurses providing nursing care in the home. This policy appears to be based on the type of patients served by the VON. Paying patients, apparently, were not to be subjected to the care of an unqualified nurse. The Minutes of October 21, 1931 state that "as no free work is being done . . . the student would receive most of her training from observation of our nursing methods and instruction from our nurses rather than giving actual bedside nursing care."[47]

Other, less tangible differences in their attitudes about student affiliation also existed. The Scott Mission actively sought student affiliations, and the only limitation on the number of students placed at the Mission at any given time appears to be living space rather than capacity to provide well supervised experiences for the students. The Mission's Board never, until 1937, addressed the issue of what roles student nurses might assume within the agency, nor did it place any specific limits on what students could or could not do in the course of a home visit. In contrast, the VON was much less open to having students affiliate with them, limited the number of students who could be placed at any given time to one or two, and actively created policies which limited the scope of their practice. Once the University of Manitoba established certificate courses in public health nursing in 1942, the VON severed its association with the hospital training schools

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[46]VON, Winnipeg Branch. Minutes of July 11, 1928, November 21, 1928, October 21, 1931, and November 18, 1931; *The Thirty-First Annual Report*, 15.

[47]VON, Winnipeg Branch. Minutes of October 21, 1931.

in favour of facilitating the education of nurses seeking advanced preparation in public health nursing.[48]

Finally, the VON adopted a very different approach to the provision of nursing services in the community. Unlike the Scott Mission, which focussed almost exclusively on charitable nursing services, the VON regularly sought opportunities to provide a range of services in Winnipeg and its surrounding suburbs. This more entrepreneurial approach to visiting/public health nursing was encouraged by the Central Board and the Chief Superintendents, who regularly spoke at local VON Board meetings and Annual Meetings about the range of educational and preventive programs that the VON were offering in other Canadian cities. In 1910, Mary Ard MacKenzie, the National Superintendent, suggested that the VON should form committees in St. James or other suburbs which might be interested in supporting a nurse. The Board, however, "agreed with the President that just now this is not necessary."[49] At the Fourteenth Annual Meeting, in 1915, MacKenzie "spoke of the thorough training given to nurses fitting them to be employed by City Councils as 'Public Health Nurses' . . . and expressed regret that they were not thus made use of in Winnipeg."[50] In 1922, MacKenzie's successor, Christina Hall, recommended that the work of the Winnipeg Branch be expanded "especially along

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[48]Hart and McLeod, *History of the University of Manitoba School of Nursing*, 3; VON, Winnipeg Branch. Minutes of October 1943; June 14, 1944. Actual day of the October 1943 meeting is not recorded in the minutes.

[49]VON, Winnipeg Branch. Minutes of October 12, 1910.

[50]VON, Winnipeg Branch. Minutes of the Fourteenth Annual Meeting held November 15, 1915. These minutes are recorded in the Board Minute Book.

the lines of Welfare Work, Public Health Nursing and Education of the mothers."[51]

In the early years of the VON's existence in Winnipeg, the Board seemed content to offer only visiting nursing services in Winnipeg proper. However, by the second decade it began to adopt a more entrepreneurial approach to its operations. In 1914, after protracted negotiations, the VON formalized an agreement with the Metropolitan Life Insurance Company to provide visiting nursing services for that company's policy holders.[52] This decision brought the Winnipeg Branch into line with other Local Branches in Canada, and with visiting nursing associations across the United States, which had entered into contractual arrangements with Metropolitan Life as early as 1909.[53] Although the provision of insured nursing services generally brought financial stability to participating Local Branches, the arrangement was controversial in some quarters. The Toronto Branch, for example, also initially refused to negotiate with Metropolitan Life because they believed that an association with a business concern was incompatible with the higher calling of the VON.[54] Working with "Mother Met," as visiting nursing associations across the United States and Canada learned, was an arrangement not entirely compatible with their philanthropic origins. Dr. Lee Frankel, head of the Company's Welfare Division, imposed strict accounting procedures and practice

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[51]VON, Winnipeg Branch. *The Twenty-First Annual Report,* 6.

[52]VON, Winnipeg Branch. Minutes of March 8, 1911, Dec. 13, 1911, February 14, 1912, October 14, 1914; *The Fourteenth Annual Report,* 6.

[53]Buhler-Wilkerson, *False Dawn*, 68; Bulher-Wilkerson, *No Place Like Home*, 147.

[54]Penney, *A Century of Caring,* 46-47, 60.

protocols on participating visiting nursing associations, forcing them to create better systems of record keeping, and to increase the efficiency of their nursing staff.[55] In a campaign to hold the Company's costs to a minimum, Frankel eventually forced many visiting nursing associations to employ non-nursing personnel to perform routine procedures at a lower cost and to take primary responsibility for visiting chronically ill patients.[56] Although the administrative practices imposed by their association with the Metropolitan Life Insurance Company no doubt contributed to the VON's long-term survival, they also introduced an additional level of external regulation of the VON's affairs and created administrative headaches for some Local Branches. In Winnipeg, for example, the cost of a Metropolitan Life visit was often not recovered by the fees set out in the contractual agreement, and made it appear that the VON was actually subsidising Metropolitan Life's operations. This problem, in combination with a shortage of nurses on staff, caused the Winnipeg Branch to discontinue visits to Metropolitan Life patients in 1920.[57] Nursing services for Metropolitan Life patients were not again provided by the VON in Winnipeg until 1939.[58]

Expansion of its own visiting nursing programs enabled the VON to exploit gaps

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[55]Buhler-Wilkerson, *69-70.*

[56]Buhler-Wilkerson, *False Dawn*, 134-135; Buhler-Wilkerson, *No Place Like Home*, 149-150.

[57]VON, Winnipeg Branch. Minutes of October 16, 1918, March 6, 1919, June 18, 1919; *The Nineteenth Annual Report*, 6.

[58]VON, Winnipeg Branch. Minutes of Sept 20, 1939; *The Thirty-Eighth Annual Report,* 5.

in the services provided by other local health care agencies. In 1920, using Red Cross funding, the VON aggressively extended its visiting nursing program outside of the Scott Mission's catchment area. Unencumbered by the need to differentiate itself from the "purely charitable work" of its sister organization, it provided the full range of full-pay, part-pay and charitable visiting nursing services in up to twelve adjacent municipalities. To support its visiting nursing program, the VON also established a Mother's Helper program in 1921. Families on the VON caseload could request the services of a homemaker, which was provided at the family's cost through the VON office.[59] An Hourly Nursing program was established in 1923 to enable wealthier patients to hire a nurse of their choosing to attend them at specified times during the day.[60]

Health education programs were also initiated in the early 1920s, including mothercraft, first aid, and home nursing classes that were offered to both school aged girls and adult women.[61] Prenatal visits were made to VON clients beginning in 1922. This program proved so successful that individual home visits were soon replaced by group instruction in the North End, St. James, and at the VON Office.[62] They were ultimately requested by the City Health Department to discontinue these programs within

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[59]VON, Winnipeg Branch. *The Twentieth Annual Report*, 15. Regular mention of this program appear in subsequent annual reports and in the Minutes.

[60]VON, Winnipeg Branch. *The Twenty-Second Annual Report*, 6; *The Thirty-First Annual Report,* 4.

[61]VON, Winnipeg Branch. *The Twentieth Annual Report*, 7; Minutes of Feb 28, 1928.

[62]VON, Winnipeg Branch. *The Twenty-First Annual Report,* 6; Minutes of October 15, 1924.

the city limits to reduce the overlapping between their programs and those of the city's public health nurses.[63]

Between 1922 and 1926, the VON, in a departure from their usual practice, operated a clinic in Winnipeg's North End. Inspired by their perception that Ukrainian women were "greatly neglected and downtrodden by their men," the VON offered a range of prenatal and health education programs to this group.[64] Although not intended to be a charitable endeavour, the VON experienced great difficulties in collecting fees from the women who attended the clinic, and they often had to subsidize the salary of the physician who attended the clinic out of their operating budget. Optimistic hopes that the clinic would eventually pay for itself never materialized. The Board agonized about the necessity of not allowing the women to impose upon the Order, because charitable services were the domain of organizations such as the Scott Mission or the Federated Budget Board of Winnipeg. At the same time, the Board remained convinced that the VON could play an important role in Canadianizing this group of immigrants, and limit the possibility that they would fall under the influence of "communistic forces" widely believed to be at work recruiting supporters amongst the Ukranian youth.[65] To the evident relief of many Board members, the Ukrainian Clinic was closed when an Out-Patients Department was opened at St. Joseph's Hospital and the patients were referred to it for

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[63]VON, Winnipeg Branch. Minutes of November 18, 1925.

[64]VON, Winnipeg Branch. *The Twenty-First Annual Report,* 6, Minutes of November 18, 1925.

[65]VON, Winnipeg Branch. See, for example, the Minutes of March 27, 1923, May 11, 1923, January 16, 1924, November 19, 1924, March 18, 1925, September 15, 1925.

medical care.[66]

The Winnipeg Branch of the VON also established Canada's first industrial nursing program in 1922. In return for a set fee, VON nurses were assigned to work in two large Winnipeg department stores to assess the health of employees and provide home nursing services as needed. This program lasted until 1929.[67] There was a brief revival of the industrial nursing program during the Second World War when the VON cooperated with the Industrial Hygiene Section of the Provincial Department of Health to provide occupational health services to several large manufacturing companies. However, this work ended in 1946 when women were no longer employed in factories.[68]

The VON also expanded its programs by offering public health programs that were not being provided by the local health authorities. In 1922, the VON approached the city health department about the feasibility of allowing its nurses to provide prenatal care within the city limits. A. J. Douglas, the city's medical health officer, agreed that prenatal services were needed, but stated that he could not fund the program. In early 1925, the VON was contacted by A. G. Lawrence, Manager of the city's Child Hygiene program to re-open these discussions. The arrangement suggested was that the VON would provide prenatal instruction and post partum care, and then refer the babies to the Child Welfare

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[66]VON, Winnipeg Branch. April 26, 1926.

[67]VON, Winnipeg Branch. *The Twenty-First Annual Report,* 6; Minutes of April 18, 1923, March 17, 1926, March 16, 1927, September 18, 1929.

[68]VON, Winnipeg Branch. *The Forty-First Annual Report,* 16; Minutes of November 19, 1942, March 13, 1946.

Nurses.[69] The scheme never came to fruition. Despite assurances that the health department would cooperate fully, the VON received few referrals for prenatal care from the city nurses.[70] In addition, the VON was reluctant to simply hand over the care of post partum mothers and newborns to the city nurses because they believed that the VON was accountable to the patient's physicians rather than to the health department. Many physicians did not want their patients referred to the city nurses because "the relations between the med. (sic) profession & the child welfare nurses were not cordial."[71]

The VON met much greater success in its efforts to cooperate with the provincial department of health. It took advantage of the slower development of local health units in municipalities adjacent to Winnipeg to provide well baby clinics on behalf of the local health units. In the municipality of St. James, a clinic was established in December of 1925.[72] Well baby clinics were also established in Fort Garry and East Kildonan in 1934.[73] All three clinics were taken over by the local health units in 1942.[74]

Thus, between 1905 and 1941, the Scott Mission and the VON developed distinct

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[69]VON, Winnipeg Branch. Minutes of Special Executive Meeting of February 6, 1925.

[70]VON, Winnipeg Branch. Minutes of March 31, 1925, October 20, 1926.

[71]VON, Winnipeg Branch. Minutes of September 16, 1925, November 18, 1925, February 17, 1926.

[72]VON, Winnipeg Branch. Minutes of December 30, 1925; *The Twenty-Fourth Annual Report,* 6.

[73]VON, Winnipeg Branch. *The Thirty-Third Annual Report*, 6.

[74]VON, Winnipeg Branch. Minutes of March 11, 1942.

identities within Winnipeg. The boundaries between the two organizations could be discerned by their organizational cultures, the type of nursing care they provided, their relationship with the medical community, and their adherence to increasingly higher educational standards for nurses working in the community. Although both organizations began their existence as philanthropic female-led providers of bedside nursing care in the community, the VON created a broader approach to the practice of visiting nursing, and more professional working relationships with physicians, charity organizations, and politicians. However, as an analysis of the two organizations' financial records reveals, these developments did not, for much of the period under study, confer greater financial stability or administrative independence on the VON.

The Impact of Finances on the Administrative Independence of Visiting Nursing Organizations: The Case of the Scott Mission and the VON

This section analyses the financial statements of both the VON and the Scott Mission. It identifies the extent to which their respective financial arrangements were consistent with the division of their work between charitable and paying patients. Trends in the sources of their revenues over time are identified. Particular attention is paid to the increased dependence both organizations developed on public funding from the city and provincial governments. As well, their increased dependence on charitable funding is identified and discussed. In the final analysis, the VON's greater dependence on external funding resulted in a loss of both fiscal and administrative autonomy.

Income from Patient Fees

Visiting nursing associations generated at least a part of their revenues by charging patients a fee for services rendered. Patient fees were usually based on the family's ability to pay.[75] Winnipeg's "purely charitable visiting nursing agency," the Margaret Scott Nursing Mission, provided free nursing care to the destitute. Its Board viewed the Mission's work amongst the city's poorest citizens as a sacred duty and successfully retained this mandate throughout an era when numerous other health care and social service agencies established operations in Winnipeg.[76] The Mission asked for nothing and received little from its patients. No fee schedule was ever developed. Patients who could make a partial payment for the nursing care they received were encouraged to do so. However, revenues from this source were labelled as "patient donations" rather than "patient fees." Between 1905 and 1942, patient donations made only a minimal contribution to the Mission's revenues. (Table 5-1).

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[75]Fitzpatrick, *The National Organizations for Public Health Nursing*, 8.

[76]The minutes of the Margaret Scott Nursing Mission, the Winnipeg Branch of the VON, and the Civic Charities Bureau of the City of Winnipeg all, at one time or another, contain statements to the effect that the Mission's mandate was "nursing the poor without remuneration." See, for example, a copy of the minutes of a meeting of the Civic Charities Bureau of the City, dated September 28, 1914 which are located in the Mission's papers. It states, in part, that the VON, the Mission, and the City's Child Welfare Department were "obviously co-operating with the others and each had its distinct and specific work." See: AM, The Mission papers, MG10, B9, Box I.

Table 5-1: Margaret Scott Nursing Mission Analysis of Revenues and Costs

Year	Revenue							Expenses	Balance
	Total Revenue	Patient Donations		Government Grants		Other Revenue			
		Actual	%	Actual	%	Actual	%		
1904									
1905(1)	7643.27	____	0	2000.00	26	5643.27	74	6427.54	1215.73
1906	7101.35	311.65	4	2392.87	34	4397.48	62	6768.93	332.42
1907	5964.12	414.65	7	3378.49	57	2170.98	36	6395.22	[431.10]
1908	5640.06	217.10	4	3021.99	54	2400.97	43	6058.19	[418.13]
1909	5870.72	362.85	6	2900.00	49	2607.87	44	5369.41	501.31
1910	____	____	_	____	_	____	_	____	____
1911	____	____	_	____	_	____	_	____	____
1912	____	____	_	____	_	____	_	____	____
1913	9212.76	369.00	4	4172.50	45	4671.26	51	8661.42	551.34
1914	6504.20	190.75	3	4190.50	64	2122.95	33	8132.69	[1628.49]
1915	9161.58	235.90	3	4650.00	51	4275.68	47	7430.61	1730.97
1916	____	____	_	____	_	____	_	____	____
1917	____	____	_	____	_	____	_	____	____
1920	7870.20	484.75	6	3100.00	39	4285.45	54	9082.85	[1212.65]
1921	11649.67	434.80	4	5100.00	44	6114.87	52	11153.22	496.45
1922	14545.76	509.00	3	5100.00	35	8936.76	61	10965.72	3580.04
1923	11972.07	452.00	4	5100.00	43	6420.07	54	12152.46	[180.39]
1924	____	____	_	____	_	____	_	____	____
1925	11775.79	317.55	3	5349.99	45	6108.25	52	12270.66	[494.87]
1926	12995.42	406.90	3	5850.00	45	6738.52	52	11125.08	1870.34
1927	14995.78	454.55	3	5100.00	34	9441.23	63	11513.80	3481.98
1928	11739.36	471.95	4	5100.00	43	6167.41	53	15941.65	[4202.29]
1929	10649.68	441.45	4	5100.00	48	5108.23	48	10962.02	[312.24]
1930(4)	18366.23	254.25	1	5100.00	28	13011.98	71	10408.24	7957.98
1931	11549.39	159.80	<1	5100.00	44	6289.59	55	22309.76	[10760.37]
1932	8786.87	73.50	<1	750.00	9	7963.37	91	10594.86	[1807.99]

Year	Revenue							Expenses	Balance
	Total Revenue	Patient Donations		Government Grants		Other Revenue			
		Actual	%	Actual	%	Actual	%		
1932	8786.87	73.50	<1	750.00	9	7963.37	91	10594.86	[1807.99]
1933	---	---	---	---	---	---	---	---	---
1934	10816.61	51.50	<1	4275.00	40	6490.11	60	8843.22	1973.39
1936	8475.29	86.00	<1	4275.00	50	4114.29	49	8348.70	126.59
1937	9158.93	37.90	<1	4275.00	47	4846.03	53	11149.85	[1990.92]
1938	12267.28	47.35	<1	4275.00	35	7944.93	65	11466.90	800.38
1939	10157.03	15.95	<1	4275.00	42	5866.08	58	11915.93	[1758.92]
1940	12214.43	37.10	<1	4275.00	35	7902.33	65	12449.89	[235.46]
1941	12087.23	55.60	<1	4275.00	35	7756.63	64	11631.51	455.72
1942	6211.84	11.00	<1	1200.00	19	5000.84	81	6708.20	[496.36]

Source: AM, Margaret Scott Nursing Mission Annual Reports.
(1) Totals do not add up in report
(2) Includes period Oct. 1, 1914 - Dec. 31, 1915
(3) $25,000 per year for 3 years from Red Cross. Hired 2 more nurses
(4) Includes two $5000.00 bequests

The vigour with which the Scott Mission protected its mandate limited the VON's options.[77] However, the VON made the most of its circumscribed field of practice by exploiting the middle ground between a client's hiring a private duty nurse at considerable expense and accepting the charitable and free services of a Mission visiting nurse.[78] Its services were promoted as being "available not only in cases of poverty, but

[77]VON, Winnipeg Branch. Minutes of April 13, 1910. The minutes reveal that not only did the Mission express its concerns about the two agencies overlapping, it also made suggestions as to how the VON could change its regulations to solve this problem.

[78]VON, Winnipeg Branch. Minutes of the Advisory Board, July 16, 1910. In 1910, the services of a private duty nurse cost between $18 and $20 per week. In addition, the family was expected to provide room and board for the nurse. In contrast, the fee charged by the Winnipeg Branch of the VON was from $0.05 to $0.50 per visit.

amongst the better class who may not wish to engage a nurse by the week but only require her for a short part of the day."[79] As E. L. Drewry stated at the 1910 VON Annual Meeting, there was "a great need in Winnipeg of such Nurses as those of the Victorian Order where there are so many not able to pay for the services of a resident [private duty] nurse, and still not willing to be the objects of charity."[80]

Although the VON was identified as Winnipeg's non-charitable visiting nursing agency, in the period between 1915 and 1942, patient fees never exceeded fifty-three percent of the organizations's total revenues.[81] (Table 5-2)

Table 5-2: VON Winnipeg: Analysis of Revenues and Costs

Year	Revenue									Expenses	Balance
	Total Revenue	Patient Fees		Government Grants		Federated Budget		Other Revenue			
		Actual	%	Actual	%	Actual	%	Actual	%		
1915	5107.03	2689.55	53	1000.00	19			1417.48	28	6925.80	[1818.77]
1916	6975.13	3554.50	50	1000.00	14			2420.93	35	7148.39	[173.26]
1917	9956.45	4394.20	44	2000.00	20			3562.25	36	8613.17	1344.28
1918	6928.20	3693.35	53	1500.00	22			1734.85	25	8177.37	[1249.17]
1919	11278.48	3797.64	34	1000.00	9			6480.84	57	9987.41	1291.07
1920 (1)	18383.97	7142.97	39	1833.00	10			9408.00	51	13338.17	5045.80
1921 (2)(3)	21921.35	9333.05	42	1500.00	7			11088.30	51	21986.34	[64.99]
1922 (4)	19747.87	9705.95	49	1500.00	8	2310.00	11	6231.92	32	24854.43	[5106.56]

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[79]VON, Winnipeg Branch. *The Fifteenth Annual Report*, 7; Minutes of March 14, 1906.

[80]VON, Manitoba Branch, Minutes of Annual Meeting, November 28, 1906.

[81]The only exception occurred in 1915, when patient fees represented 53% of the Winnipeg Branch's total revenues.

Year	Revenue										Expenses	Balance
	Total Revenue	Patient Fees		Government Grants		Federated Budget		Other Revenue				
		Actual	%	Actual	%	Actual	%	Actual	%			
1923	29012.86	11380.41	39	1500.00	5	15023.00	52	1109.45	4		30569.57	[1556.71]
1924	32234.61	11526.15	36	1500.00	4	16006.00	50	3202.46	10		32617.18	[382.57]
1925	27099.03	9960.66	37	2166.66	8	12724.00	47	2247.71	8		26531.80	567.23
1926	30172.05	10494.16	35	2000.00	7	15725.00	52	1952.89	6		26933.41	3238.64
1927 (6)	26409.05	10515.90	40	1000.00	4	12700.00	48	2193.15	8		27886.71	[1477.66]
1928	29639.68	11881.57	40	1500.00	5	13955.00	47	2303.11	8		29529.68	110.00
1929	27626.29	11084.80	40	1500.00	5	13070.00	47	1971.49	7		27662.19	[35.90]
1930	28023.87	10990.30	39	2000.00	7	13175.00	47	1858.57	7		28554.72	[530.85]
1931 (6)	25753.99	10286.80	40	1000.00	4	11700.00	45	2767.19	1		27731.59	1977.60]
1932	23678.34	7699.43	33	800.00	3	12100.00	51	3078.91	13		25520.10	[1841.76]
1933	22588.61	5938.01	26	585.00	3	12700.00	56	3365.60	15		20145.65	2442.96
1934	17314.18	4327.28	25	585.00	3	9840.00	55	2921.90	17		16668.89	645.29
1935	17050.69	4634.08	27	585.00	3	9500.00	56	2331.61	14		15665.75	1384.94
1936	12289.95	3779.15	31	585.00	5	6500.00	53	1425.80	12		16618.84	[4328.89]
1937	15765.51	4161.14	26	585.00	4	9500.00	60	1519.37	10		16229.04	[463.53]
1938	16477.71	4568.10	28	585.00	3	9900.00	60	1424.61	9		16509.46	[31.75]
1939	16713.64	4403.24	26	585.00	4	9620.00	58	2105.40	13		17120.24	[406.60]
1940	19806.49	7114.27	36	585.00	3	10000.00	50	2110.22	10		17790.03	2019.46
1941	20127.63	7781.91	39	585.00	3	10100.00	50	1660.72	8		18605.59	1522.04
1942	24881.14	7693.44	31	5200.00	21	8300.00	33	3687.70	15		23793.27	1087.87
1943	25527.83	8244.43	32	5200.00	20	10000.00	39	2083.40	8		25987.76	[459.93]
1944	26164.93	8731.31	33	5200.00	20	10000.00	38	2333.62	9		25364.35	800.58
1945	28461.33	10289.45	36	6000.00	21	10000.00	35	2171.88	8		29728.32	[1266.99]
1946	32652.86	10710.92	33	6000.00	18	10000.00	37	3941.94	12		37499.03	[4846.17]

Sources: VON, Winnipeg Branch, Annual Reports.

(1) Room & Board Charged to Nurses and Training School Students
(2) Red Cross funding: $6000.00/yr for 2 yr.
(3) Moved from Home on Sherbrooke to Office in Birks Bldg.
(4) Federated Budget; Red Cross Funding ended
(5) Revenues included $2000.00 loan
(6) No city grant

Indeed, there is no evidence that the VON even intended to recover the full cost of its operations from patient fees. Analysis of their financial records reveals that the income generated from patient fees was consistently less than their expenditures.[82] (Table 5-3) The full fee set by the Board never matched the cost of providing that visit. Between 1915 and 1946, the VON's cost per visit ranged from $0.76 (in 1916) to $1.37 (in 1936). In 1916, the maximum nursing fee charged was $0.50. The full fee of more than $1.00 per visit was never charged. Why, then, was the VON not also identified as a charitable visiting nursing organization and its patients, even those who paid the full fee, described as being the objects of charity?

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[82]In 1919, the cost per visit, as calculated from the Branch's nursing statistics and balance sheets, was actually $1.95. However, this was an extremely unusual year for the Order on a variety of fronts. A severe nursing shortage left the Local Branch understaffed and dependent on substitute nurses who had no public health training. The actual number of visits completed in that year was 5132, the lowest ever recorded by the Winnipeg Branch. In addition, nurses' salaries were raised 30% in the hope that this would enable the Branch to recruit more qualified nurses.

Table 5-3: VON Winnipeg Branch: Analysis of Revenue/Nursing Visit Vs .Cost/Nursing Visit

Year	Total Fees	Total Visits	Revenue per Visit	General Fees	General Visits	Revenue per Visit	Metro Fees	Metro Visits	Revenue/ Visit	Expenses	Actual Cost/ Visit	% Costs Covered by Fees
1915	2689.55	7505	0.36	1996.05			693.50			6925.80	0.92	39
1916	3554.50	9351	0.38							7148.39	0.76	50
1917	4394.20	8666	0.51	3036.20	6096	0.50	1358.00	2570	0.53	8613.17	0.99	51
1918(1)	3775.10	6689	0.56	2789.35	4885	0.57	985.75	1804	0.55	8177.37	1.22	45
1919	3797.64	5132	0.74	3421.14	4379	0.78	376.50	753	0.50	9987.41	1.95	38
1920(1)	7664.97	13942	0.55							13338.17	0.96	54
1921	9333.05	24970	0.37							21986.34	0.88	42
1922	9705.95	24596	0.39							24854.43	1.01	37
1923	11380.41	29088	0.39							30569.57	1.05	37
1924	8760.40	26930	0.42							29851.43	1.11	29
1925	7828.50	19262	0.52							24399.64	1.27	32
1926	8019.61	20507	0.51							24458.86	1.19	33
1927	8180.65	19819	0.53							25551.46	1.29	32
1928	8900.57	23410	0.51							26548.68	1.13	34
1929	8700.40	21658	0.52							25277.79	1.17	34
1930	8802.70	25030	0.44							26367.12	1.05	33
1931	7356.80	24064	0.43							25051.59	1.04	29
1932(2)	5305.48	23842	0.22							22993.77	0.97	23

Year	Total Fees	Total Visits	Revenue per Visit	General Fees	General Visits	Revenue per Visit	Metro Fees	Metro Visits	Revenue/ Visit	Expenses	Actual Cost/ Visit	% Costs Covered by Fees
1933	4742.26	16282	0.29							18518.02	1.14	26
1934	4327.28	14141	0.31							16668.89	1.18	26
1935	4634.08	No data	----							15665.75	----	30
1936	3779.15	12099	0.31							16618.84	1.37	23
1937	4161.14	12067	0.34							16229.04	1.34	26
1938	4568.10	13694	0.33							16509.46	1.20	28
1939	4403.24	13755	0.32							17120.24	1.24	26
1940	7114.27	17356	0.41	4605.63			2508.64			17790.03	1.03	40
1941	7781.91	17579	0.44	4744.12			3099.45			18605.59	1.06	42
1942	7693.44	23451	0.33	5364.53	20680	0.26	2328.91	2771	0.84	23793.27	1.01	32
1943	8244.42	22890	0.36				----	1566		25987.76	1.14	31
1944	8731.31	22882	0.38	7219.89			1511.42			25364.35	1.11	34
1945	10293.10	25397	0.41	8776.35			1516.75			28734.98	1.13	36
1946	12706.48	31394	0.41	10710.92			1995.56			34808.08	1.11	37

Source: VON, Winnipeg Branch, Annual Reports.

(1) From Nurses' Report, not Treasurers'
(2) from Minutes, not calculated

In part, the VON's non-charitable status was derived from the manner in which charity itself was defined. In the early 20th century, individuals became charity cases by accepting services without paying for them. Those who paid even a partial fee avoided the humiliation of "pauperizing" themselves, and retained their self-respect and the respect of others. Annie Riley, an influential Scott Mission Board member, captured the distinction between charity and respectability when she stated that "there was a great field for work in Winnipeg among people who did not wish to be classed as charity patients & who were willing to pay moderately for the services of a nurse."[83]

Within Winnipeg proper, the VON endeavoured, for the most part, to confine its activities to full pay and partial pay patients. This approach was formalized in 1910 after a letter was sent to the VON from the Corresponding Secretary of the Scott Mission in which concerns were raised that the VON was duplicating the Mission's work.[84] The VON's Board hastened to assure the Mission that "there was more than enough work for both societies to do side by side without interfering with each other in any way."[85] This statement of general good will was operationalized by the regular referral of patients from one agency to another. Those who called the VON, but were destitute, were referred to the Mission. In like fashion, patients who could pay were referred by the Mission to the

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[83]AM, The Mission papers, MG10, B9, Box IV. Minutes of May 12, 1913.

[84]AM, The Mission papers, MG10, B9, Box IV. Minutes of May 9, 1910; VON, Winnipeg Branch. Minutes of April 13, 1910.

[85]AM, The Mission papers, MG10, B9, Box IV. Minutes of May 12, 1913.

VON.[86]

However satisfactory this fine distinction between charity and self sufficiency may have been in theory, the unstable space between charitable and non-charitable visiting nursing required continual maintenance. Avoiding incursions on the Mission's mandate was a challenging proposition for the VON. Part of the difficulty stemmed from the fact that VON Board members also had an interest in the plight of Winnipeg's needy citizens and sometimes responded to 'pitiful cases' brought to their attention by the nurses. The *Annual Report* of 1915-16 records one such instance:

> Among the class of patients they visit during their rounds the nurses meet with few cases of absolute poverty but towards two families reported by them, Mrs. Fletcher Andrews has acted the part of the Good Samaritan by relieving their wants and comforting their sorrows.[87]

In the early months of the First World War, the VON's Board, obviously inspired by the general patriotic fervour of the time, offered to provide free nursing care to the families of enlisted men.[88] In 1925, the Board discussed the plight of a mother of triplets who lived in St. James. In this case, the VON was within its rights to offer free nursing care to the family because they lived outside of the Mission's catchment area. However, Mrs.

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[86]See, for example: VON, Winnipeg Branch. *The Sixteenth Annual Report*, 12; AM, The Mission papers, MG10, B9, Box VI, *The Twenty-Fourth Annual Report,* (1928), 20. Documentation of cases referred to the VON by the Mission's Nurses are also found in the Mission's case files. See, for example, Case 230 (1908), Case 3262 (1913), Case 5934 (1916) and Case 6573 (1916).

[87]VON, Winnipeg Branch. *The Fourteenth Annual Report,* (1915), 10.

[88]VON, Winnipeg Branch. Minutes June 30, 1914. After that date, regular mention of nursing care to 'patriotic cases' appear in the minutes and Annual Reports. See, for example, VON, Winnipeg Branch, *The Sixteenth Annual Report* (1917), 12.

McCarthy, a Board member, went much further when she offered to personally defray the costs associated with providing the mother with a trained assistant for a month. The VON's relationship with this family lasted until 1929, when the mother wrote to the Board stating that she hoped to be able to manage with no further assistance.[89] These actions confirm the Board's continued interest in charitable work, and their belief that they, too, had the right and duty to fulfil these social obligations when the appropriate opportunities presented themselves.

Another factor that challenged the VON's ability to avoid charitable cases was the behaviour of some of the families on their caseload. Prior to the formal agreement between themselves and the Mission, regular mention of 'free' patients appear in the minutes. So, too, does discussion of the challenges associated with collecting patient fees. The minutes of January 19, 1907 state that four patients out of an unknown total had not paid their fees, and those of December 11, 1907 state that nine paying and five non-paying patients had received nursing care during the month.[90] At yet another meeting, the corresponding secretary reported that she had written all patients who had not paid their fees. However, only one patient responded. The problem of how to deal with patients who did not pay their fees inspired considerable debate, but the issue apparently remained unresolved.[91] It actually took until 1911 for the VON to realign its case load so that it did

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[89]VON, Winnipeg Branch. Minutes of December 16, 1925, and September, 1929.

[90]VON, Winnipeg Branch. Minutes of December 11, 1907, and March 11, 1908.

[91]VON, Winnipeg Branch. Minutes of March 11, 1908.

not overlap with the charitable work of the Scott Mission. Between September 14, 1910 and April 12, 1911, approximately one half of all patients visited by the VON were classified as free cases.[92] Part of the problem may have been Miss McCollough, the Local Superintendent. Her responsibilities included the investigation of the financial circumstances of patients receiving services from the VON and the assessment of a fee based on her perception of their ability to pay. In April, 1911, just prior to her dismissal by the Board, twenty-two of forty-two patients received free nursing services. In October of that same year, under the leadership of a new Superintendent, only eight of fifty-five patients visited by the VON received free services.

Despite the fact that VON's Board was increasingly unwilling to be "imposed upon" by patients who were unable or unwilling to pay at least the minimum fee, free care continued to be provided on a limited basis until 1942. In the majority of cases, patient fees were written off the books when families initially assessed as being able to pay at least the minimum fee set by the VON, were subsequently either unable or unwilling to do so.[93] The vigour with which payment of fees was pursued was sometimes influenced by the Board's perception of the moral conduct of the individual or family involved. For example, a "troublesome case" was referred to the Board Executive on October 17, 1927. Apparently, an unmarried woman had had an illegitimate child by a policeman. He was

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[92]VON, Winnipeg Branch. Minutes of September 14, October 12 and November 9, 1910; April 12 and October 11, 1911.

[93]See, for example: VON, Winnipeg Branch, *The Nineteenth Annual Report,* (1920), 12.

subsequently arrested. The VON had been paid $5.00 in nursing fees, but were still owed $10.00 which they were apparently unable to collect from either the patient or her incarcerated lover. Having exhausted this avenue, the VON turned to the Child Welfare Department, who stated that "if there were any funds left over after the child was adopted the V.O. [N.] would be paid." Miss Peterson, the Local Superintendent, was instructed to follow up on the matter.[94]

If, on the other hand, the conduct of non-paying families was perceived by the Board as being above reproach, steps were taken to protect these unfortunates from being classified as charity cases and placed under the care of the Mission. However, in order to carry these cases, the Board was dependent on funding from external sources, such as the local and provincial governments, and the Federated Budget Board. In 1924, the VON experienced a severe cash flow problem which threatened to destabilize the entire organization. Its expenses had exceeded its revenues for the fourth consecutive year, it could not seek donations to reduce its deficit, and it had been forced to borrow $2000.00 from the bank to keep the Branch afloat until the next grant from the Federated Budget Board was received.[95] The VON Executive was frustrated with the inadequate level of financial support it received from the Federated Budget Board. They feared that, should

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[94]VON, Winnipeg Branch. Minutes of Executive Meeting of October 17, 1927.

[95]VON, Manitoba Branch. *Twenty-Third Annual Report,* (1924), 12.; Minutes of September 17, 1924 and September 29, 1924. Also, a letter from the Honourary Corresponding Secretary of the Winnipeg Branch to the Secretary of the Federated Budget Board of Winnipeg dated September 29, 1924. This letter is pasted on page 137 of the Minute Book.

the VON be unable to continue operations in Winnipeg, the only recourse for the majority of their patients would be the charitable services of the Mission. The responsibility for this intolerable state of affairs, in the Board's opinion, rested with the officials of the Federated Budget Board and their failure to raise sufficient funds to support the organizations under its umbrella.[96] When the Federated Budget Board offered no further financial assistance, the VON dismissed two nurses and bitterly reflected that "if the Fed. [sic] Budget is not taking into account the effect of charity on the morale of the people it is going to lose out."[97] In 1925, VON actually resisted following a recommendation of the Federated Budget Board that they decrease their expenses by referring patients who could pay only a minimal fee to the Mission. "Our committee" stated the Minutes, "felt that this would not be satisfactory as it would tend to pauperize."[98]

The working arrangement between the Scott Mission and the VON remained essentially unaltered during the entire period of their co-existence. However, from the VON's perspective, the Mission curtailed the VON's capacity to implement a full range of visiting nursing services in Winnipeg and monopolized the government grants necessary to perform this work. These feelings came to a head during the 1930s. The

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[96]VON, Manitoba Branch. Minutes of September 29, 1924. This was apparently a perception shared by other individuals and groups in Winnipeg. The results of the 1924 Federated Budget financial campaign were so disappointing that the Federated Budget Board of Winnipeg commissioned Dr. Edward T. Devine, "internationally regarded as an outstanding authority on the questions involved " to evaluate and report on the Federated Budget's operations. See: Devine, *Welfare Work in Winnipeg*.

[97]VON, Manitoba Branch. Minutes of October 23, 1924.

[98]VON, Winnipeg Branch. Minutes of March 19, 1925.

VON's capacity to provide non-charitable visiting nursing services was seriously compromised by the magnitude of the economic depression that gripped Winnipeg. The nurses reported much greater problems in collecting fees.[99] More patients were being cared for at the minimum fee and the Board ruefully observed that it was "doing more work for less money."[100] This developmen placed the VON in direct competition with the Mission. Both agencies were now drawing their patients from essentially the same socio-economic group. In addition, the VON was being pressured to undertake more free nursing in response to the economic crisis. In November 1931, the Local Superintendent reported that the VON was receiving requests from the *Winnipeg Tribune's* Friendship League workers for free nursing care. At this point, the Board decided to discuss the issue of which visiting nursing agency had the mandate to provide free nursing services with city officials and to obtain their advice.[101] At the December Board meeting, the President, Esther Brown, reported that further discussions regarding the VON's ability to provide free nursing care had taken place, but that no decisions would be made until the Chief Superintendent, Elizabeth Smellie, could visit the city.[102] In the meantime, the VON elected to continue to care for patients on their caseloads who now found themselves

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[99]VON, Winnipeg Branch. Minutes of September 17, 1930. At the meeting, the Local Superintendent reported that she hoped that $50 in outstanding fees could eventually be collected, but that they would likely be unable to collect an additional $110-15 in unpaid fees.

[100]VON, Winnipeg Branch. Minutes of September 16, 1931 and October 21, 1936.

[101]VON, Winnipeg Branch. Minutes of November 18, 1931.

[102]VON, Winnipeg Branch. Minutes of December 30, 1931.

unable to pay for nursing services. In addition, they decided to handle all requests for prenatal care, and to turn those who could not pay over to the Mission for obstetrical and post natal care.[103]

In September, 1931, the VON's Board actually questioned whether or not the Mission could cope with all of the charitable work currently needed within Winnipeg. It authorized its President to meet with the Mission's President, Mrs. MacMahon.[104] This meeting, apparently, never took place. At a special meeting of the VON Board Executive, the Advisory Committee on Nursing, and the Medical Advisory Board on December 30, 1931, a full discussion of the problem of free nursing in Winnipeg took place and "all agreed that the Victorian Order was placed in an awkward situation at the moment."[105] Further consultations between the VON, the Mission, and the Winnipeg Foundation did little to resolve the problem. Although the VON received permission to carry a number of previously paying patients on their caseloads as free work, it appears that the Scott Mission retained its mandate to be the sole provider of all charitable nursing care within the city of Winnipeg.[106]

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[103]VON, Winnipeg Branch. Minutes of December 9, 1931.

[104]VON, Winnipeg Branch. Minutes of September 16, 1931.

[105]VON, Winnipeg Branch. Minutes of Executive meeting, December 30, 1931.

[106]VON, Winnipeg Branch. Minutes of February 17, 1932. There is also attached to the minutes, on page 142, a letter from Esther Brown, President of the Board to Mr. Peter Lowe of the Winnipeg Foundation dated February 1, 1932. This letter provides a list of 16 patients who "because of existing conditions are unable to pay at present."

Income from External Sources: Fund Raising and External Grants

As demonstrated in the analysis of revenues from patient fees, neither the Scott Mission nor the VON recovered a substantial portion of their operating expenses from patient fees. In fact, in any given year, a significant proportion of the nursing visits to the citizens of Winnipeg were free or partially subsidized. The difference between the fees collected and the actual cost of providing the nursing care was generally made up through fund raising, grants from organized charities such as the Red Cross or the Federated Budget Board, and government grants. It is here that a second major difference between the VON and the Mission can be discerned.

The pattern of revenues received by the Scott Mission reflected its organizational ethos. Its founder, Margaret Scott, held deeply spiritual and traditional beliefs about charity. Like the many lady visitors of mid-nineteenth century Britain who both preceded and inspired her, Scott believed that the most sincere charity workers worked for nothing.[107] Therefore she never accepted any remuneration beyond free board and room at the Mission. Scott also shared with charity workers both past and contemporaneous a concern that there should be no overlapping between charitable agencies.[108] In 1908,

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[107]Woodroofe, *From Charity to Social Work,* 97.

[108]One of the stated goals of the Margaret Scott Nursing Mission was to "Cooperate in its work with all Churches and Clergy of the City and Benevolent Associations prosecuting like or similar charitable objects." AM, The Mission papers, MG10, B9, Box VI. *The First Annual Report,* (1905) 1. Coordination of services was a major goal of the charity organizations movement. Many sources analyzing the origins of charity organizations initiatives of the late nineteenth and early twentieth century in both Britain and the United States identify the lack of coordination between charities as one problem that a more centralized system of dispensing charity was supposed to resolve.

Principal D. W. McDermid, President of Winnipeg's Associated Charities organizations, identified Scott as the individual who brought this problem to the attention of charity workers in Winnipeg.[109] However, Scott did not support the other objective of the organized charity movement; that of centralizing and coordinating a single public campaign for charitable donations.[110] She believed that any donations received by the Mission should be unsolicited. During her lifetime, Scott "never made any appeals for the support of her work . . . she simply did her work and left it with God to supply all her need."[111] Her belief that the work of the just was a sufficient inspiration for those interested in supporting charitable causes was the basis of her consistent rejection of opportunities for the Mission's participation in the active solicitation of charitable donations.

This policy made the Mission more dependent on direct government grants and individual charitable donations. Between 1905 and 1940, government grants made up between nine and sixty-four percent of the Mission's revenues, and individual donations made up from thirty to ninety-one percent (Table 5-1). The Mission received the major

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See, for example: Mowat, *The Charity Organisation Society 1869-1913*, 2; Rooff, *A Hundred Years of Family Welfare,* 31; Woodroofe, *From Charity to Social Work*, 23.

[109]*Manitoba Free Press*, "Margaret Scott Nursing Mission Annual Reports Show Wide and Increasing Usefulness of Institution", November 2, 1908.

[110]Devine, *Welfare Work in Winnipeg,* 11; Rooff, *A Hundred Years of Family Welfare,* 51; Wills, *Marriage of Convenience,* 6, 39-40.

[111]AM, The Mission papers, MG10, B9, Box VI, *The Twenty-seventh Annual Report,* 11.

proportion of its government grants from the city of Winnipeg, presumably in recognition of the fact that its services were provided to Winnipeg's indigent population. Had these services not been available, the city Council would have had to have made other arrangements to provide this care.[112] In all probability, these patients would have been admitted to the charity wards of the Winnipeg General Hospital. This was a much more expensive option than caring for them at home. During the first fifteen years of the Mission's existence, individual charitable donations, augmented by government grants were the normal components of the revenues of most charitable organizations. However, this approach to charity changed during and after the First World War, and brought with it significant challenges to the Mission's capacity to retain its original beliefs about charitable work[113].

As early as the mid-nineteenth century, organizations and individuals involved in relief and charitable activity had become frustrated with the seemingly indiscriminate and unorganized manner in which these efforts were carried out. Early organizing initiatives were short lived efforts that had limited impact.[114] The Charity Organisation Society, founded in London, England in 1869, is generally identified as the first organization to

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[112]AM, The Mission papers, MG10, B9, Box VI. *The First Annual Report,* 5.

[113]Wills, *Marriage of Convenience,* 6. Wills identifies this period as the time when the idea of federated finance organizations really took hold in Canada.

[114]Brief histories of these early efforts to coordinate the work of charity organizations is discussed by several sources. See, for example: Mowat, *The Charity Organisation Society 1869-1913*; Rooff, *A Hundred Years of Family Welfare*; Woodroofe, *From Charity to Social Work.*

have a significant impact on the coordination and centralisation of charitable services.[115] Similar initiatives were subsequently established in the United States and Canada.[116] In all three countries, the aims of charity organization agencies were essentially the same. First, organized charities were responsible for coordinating charitable services in a way that would reduce duplication of services and material relief provided to individuals and families. This included the centralization of fund raising campaigns in support of all agencies belonging to the central body. Second, by providing an alternative to socialism, these organizations were intended to stabilize and preserve the existing social order. Third, organized charity sought to restore the indigent to self-reliance and independence, thus preventing the pauperism commonly thought to be an inevitable outcome of indiscriminate charity and/or the provision of charitable services by the state.[117]

In Winnipeg, concerns about the impact of indiscriminate and uncoordinated charitable work were evident at the turn of the twentieth century. Indeed, one of the objectives in founding the Mission was "to organize, centralize and systematize the work

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[115]Humphreys, *Poor Relief and Charity 1869 - 1945*; Mowat, *The Charity Organisation Society 1869-1913*; Rooff, *A Hundred Years of Family Welfare*; Kathleen Woodroofe, *From Charity to Social Work.*

[116]The first Charity Organization Society in the United States was founded in Buffalo, NY in 1877. Toronto formed the Federation for Community Service in 1918. Wills, *Marriage of convenience,* 5; Kathleen Woodroofe, *From Charity to Social Work,* 90.

[117]Humphreys, *Poor Relief and Charity,* 1-22; Mowat, *The Charity Organisation Society 1869-1913,* 1-18; Rooff, *A Hundred Years of Family Welfare*, 23-34; Wills, *Marriage of Convenience*, 14-17; Woodroofe, *From Charity to Social Work,* 3-24.

of nursing the poor."[118] In 1907, Magistrate Thomas Mayne Daly, speaking in support of the Mission's work, called for "co-operation in the distribution of charity" and suggested that there should be a meeting of Winnipeg's charitable organizations to implement this strategy.[119] In 1908, the Associated Charities was formed to organize the city's various charitable organizations.[120] Winnipeg's social elite were evidently preoccupied with the fear that some, possibly undeserving, individuals could benefit disproportionately from uncoordinated charity. The concern about overlapping services continued to be a major focus throughout the period under study. In 1925, the Federated Budget Board of Winnipeg hired an American consultant, Edward T. Devine, to survey its operations. One of the motives for commissioning this review was the concern that several of the member agencies might be duplicating services.[121] Exhortations for better coordination of services

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[118]*Winnipeg Telegraph*, "Nurses' Home is Assured Fact: Enthusiastic Meeting Decides on Its Immediate Organization" May 26, 1904.

[119]AM, The Mission Papers, MG10, Box IV, Undated newspaper article pasted into the 1907 Minute Book.

[120]The first superintendent of Winnipeg's Associated Charities was John Howard Toynbee Falk, who had worked in Liverpool and at Christadora House in New York City prior to his arrival in Winnipeg in 1908. In 1918, he left Winnipeg to accept the appointment as first director of the Department of Social Study and Training at McGill University. He resigned from this position in 1922, apparently because of a philosophical disagreement with Stephen Leacock about the direction that the Department should take in the education of social workers. Christie & Gauvreau, *A Full-Orbed Christianity*, 109, 132-34, 301n4: Wills, *Marriage of Convenience,* 20.

[121]Devine, *Welfare Work in Winnipeg,* Foreword. Devine was an internationally known expert in the field of social work and charity organization. He served as a professor of Social Economy at Columbia University, as General Secretary of the Charity Organization Society of New York City and as the editor of *The Survey*. He was also the author of several monographs on the topic of social work and charity organizations,

were more numerous during economic downturns. For example, the 1925 survey of the Federated Finance Board's operations was inspired by a significant decrease in donations during the 1924 campaign.[122] In the 1930s, efforts to prevent overlapping services were re-doubled. In 1937, Alderman Margaret McWilliams spoke to the VON Board about "overlapping of visitors to the homes of the indigent."[123] She reported that:

> The Central Council of Social Agencies are studying a plan to try and arrive at a solution to do away with overlapping. It is estimated that 156 workers of all kinds enter the homes of the indigent, and they feel that there must be some way of combining and reporting, that would do away with a good part of this work.[124]

The first round of discussions about a single campaign to solicit donations for all charitable works in Winnipeg occurred in 1917.[125] Instead of having each charitable organizations do its own fundraising, the proposed new approach would conduct one "whirlwind" door to door campaign and distribute the resulting funds to participating

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including one work in the four volume series entitled American Social Progress, published between 1905 and 1909. This biographical information was found in: Devine, *Misery and Its Causes.*

[122]Devine, *Welfare Work in Winnipeg,* Foreword.

[123]VON, Winnipeg Branch. Minutes of April 21, 1937.

[124]VON, Winnipeg Branch. Minutes of April 21, 1937.

[125]VON, Winnipeg Branch. Minutes of May 16, 1917. A letter from Federated Finance, explaining how the system would work, was received by the Winnipeg Branch Board on that date. The Board decided to consult their Advisory Board, and a meeting was called for May 21, but the results of that meeting are not documented.

members.[126] The Federated Budget Board, which administered both the campaign and the resulting funds, commenced operations in 1922.

Changes in the manner in which charity was organized in Winnipeg posed a significant threat to the financial stability of both the Scott Mission and the VON. For the Mission, the problem was that the city of Winnipeg might reduce its grant on the strength of the argument that the Federated Budget was now the appropriate source of funds for all charitable organizations.

The VON on the other hand, managed its financial affairs in a manner that regularly took advantage of changing social beliefs and values about charity. From the time of its founding in 1901, the VON actively engaged in fund raising activities. Between 1905 and 1922, regular mention of bonnet hops, bridge parties, rummage sales, stamp sales, and the active solicitation of subscriptions from prominent individuals and businesses appeared in the Board Minutes and Annual Reports. The VON participated in discussions regarding the establishment of a Federated Budget scheme. For them, the major drawback was the prohibition on all other forms of fundraising to supplement grants from the Federated Budget Board. After weighing the pros and cons of this initiative, however, the VON decided to participate.[127]

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[126]VON, Winnipeg Branch. Minutes of Special meeting with the Advisory Committee, October 4, 1922.

[127]VON, Winnipeg Branch. Minutes of May 18, 1921, September 20, September 27 and October 4, 1922. The Federated Budget was first discussed on May 17, 1917. On May 18, 1921 the Board received a letter from the Community Council of Social Agencies asking if the VON would participate in this initiative. This was followed up by a letter from Mr. Davidson, asking the same question, on September 10, 1922. The

After the VON joined the Federated Budget in 1922, the pattern of its revenues was significantly altered. Between 1915 and 1922, patient fees made up between forty-nine and fifty-three percent of its revenues. After 1922, revenues from patient fees decreased to between twenty-two and forty-one percent of its total income. Prior to 1922, government grants made up between seven and twenty-two percent of the Winnipeg Branch's revenues. Between 1922 and 1940, this portion of their revenues fell to from four to seven percent of their total income (Table 5-2).

Fundraising and charitable donations were an important source of income for the VON until 1922, making up between twenty-eight and fifty-seven percent of their total revenues. After joining the Federated Budget in 1922, the VON's income from fundraising fell to between one and seventeen percent of its total revenues. During this era, the reduced revenues from patient fees, fundraising, charitable donations and government grants were offset by new funding from the Federated Budget Board. Between 1922 and 1940, the revenues from this source represented eleven to sixty percent of the VON's income (Table 5-2).

Careful analysis of the financial records of both visiting nursing agencies reveals a steady dependence on government grants and charitable donations, including grants from organized charity. (Table 5-1, Table 5-2) Although the sources of funding were different for each agency, the net result was the same. Neither could survive without significant

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Executive met to discuss this issue on September 22, 1922, and the Board endorsed joining the Federated Budget on October 4, 1922.

financial support from City Council, the provincial government, the Winnipeg Foundation, and, in the case of the VON, the Federated Budget Board.

The VON's financial situation during the Great Depression was extremely precarious. In the previous decade, it had extended its visiting nursing services to several adjacent municipalities. However, the financial support received from the Red Cross to support this expansion never covered the total costs incurred by the VON.[128] When the VON joined the Federated Budget in 1922, the Red Cross withdrew its financial support.[129] The provincial government, which had been granting the VON $1000 per annum since 1916, did not increase its financial support during the VON's expansion into areas under the jurisdiction of the provincial health department. In fact, in 1932, it reduced its grant to $800 per annum, and in 1933, further reduced its financial support to $585 per annum. During that same decade, city grants to the VON were reduced from a high of $1000 in 1930 to nothing in 1931. From 1934 to 1940, while the Scott Mission was receiving government grants totalling $7275 per annum, the VON was receiving only $3085. To compound their financial woes, revenues from patient fees and the Federated Budget also decreased significantly during this decade. The only bright spot in their otherwise dismal financial situation was that the Winnipeg Foundation increased its financial support from $850 in 1929 to between $1000 and $3000 during the years of the Great Depression. (Table 5-2)

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[128]VON, Winnipeg Branch. *The Nineteenth Annual Report,* (1920) 6.

[129]VON, Winnipeg Branch. Minutes of October 18, 1922; *The Twentieth Annual Report,* (1921) 5-6.

By 1934, the VON's financial status was so precarious that the Nursing Advisory committee recommended its nurses be put on half pay, but kept working full time.[130] When the Local Superintendent informed the Board that there was not sufficient work available to keep the nurses occupied full time, several other options to reduce salary costs while retaining their entire staff of nurses were considered. Finally, it was decided that each nurse would have to take one month of unpaid vacation during the year and that their paid vacation would be reduced from four to three weeks.[131] As well, one nurse was transferred from the Winnipeg Branch as a cost saving measure.[132] In 1935-36, the VON employed only seven nurses in Winnipeg, a reduction of four from its 1930 staffing complement.[133] It increased its staff to eight in 1937, and continued to employ a maximum of eight nurses until 1941.[134] (Table 5-4)

Between 1910 and 1931, there was little interaction between the VON and the Scott Mission. However, beginning in 1931, the VON Board began to openly debate whether or not the Mission could manage the volume of free nursing cases alone, and

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[130]VON, Winnipeg Branch. Minutes of January 26, 1934.

[131]VON, Winnipeg Branch. Minutes of April 10, 1934 and Executive Minutes of April 16, 1934.

[132]VON, Winnipeg Branch. Minutes of Executive Meeting of September 18, 1934.

[133]VON, Winnipeg Branch. *Twenty-Ninth Annual Report,* (1930) 6; *The Thirty-Fourth Annual Report,* (1935) 5.

[134]VON, Winnipeg Branch. *The Thirty-Fifth Annual Report,* (1936) 6; *The Thirty-Sixth Annual Report,* (1937) 5; *The Thirty-Seventh Annual Report,* (1938) 5; *The Thirty-Eight Annual Report,* (1939) 5; *The Thirty-Ninth Annual Report,* (1940) 5; *The Fortieth Annual Report,* (1941) 5.

actually offered to assist them.[135] Meetings between city officials and the VON President resulted in a tentative plan for a division of the free nursing services between the VON and the Mission. Esther Brown reported at the December, 1931 Board meeting that she hoped that the city might be divided into "zones" for the delivery of free nursing services.[136] It is apparent that the VON hoped that these districts would be divided between themselves and the Mission so that they could receive a share of the Mission's city grant. They were seeking "some arrangement . . . which would tide us over at the present time."[137] However, their offers of assistance in this work, in return for a share of the government grants, were met with stiff resistance by the Mission.

Table 5-4: VON Nursing Staff Numbers, 1905-1946

Year	# Nurses	Year	# Nurses	Year	# Nurses	Year	# Nurses	Year	# Nurses
1905	1	**1914**		**1923**	14	**1932**	10	**1941**	8
1906	2	**1915**	7	**1924**	12	**1933**	10	**1942**	13
1907		**1916**	8	**1925**	9	**1934**	9	**1943**	12
1908		**1917**	8	**1926**	9	**1935**	7	**1944**	12
1909		**1918**	8	**1927**	10	**1936**	7	**1945**	12
1910	6	**1919**		**1928**	11	**1937**	8	**1946**	15
1911		**1920**	15	**1929**	12	**1938**	8		
1912		**1921**	16	**1930**	11	**1939**	8		
1913		**1922**	16	**1931**	10	**1940**	8		

[135]VON, Winnipeg Branch. Minutes of September 16, 1931.

[136]VON, Winnipeg Branch. Minutes of December 9, 1931.

[137]VON, Winnipeg Branch. Minutes of Executive and Advisory Council meeting of December 30, 1931.

Throughout the decade, the Boards of both visiting nursing agencies called for greater cooperation between the two agencies. From the perspective of the Scott Mission's Board, it can only be assumed that their willingness to coordinate activities with the VON was inspired by a firm conviction that the VON needed to understand and respect their mandate to provide free nursing services in the city. When the President and Secretary of the VON visited the Mission's Board in May of 1935, the minutes report that the VON president stated that the VON should coordinate with their agency.[138] Whether this was in fact the sentiment of the VON Board, or the Mission's hopeful interpretation of the same is not possible to determine. What is evident, however, is that both visiting nursing agencies were acutely aware that the always unstable space which had separated their distinct areas of practice in Winnipeg had narrowed to the point where direct competition was almost inevitable. Further, both organizations likely knew that the VON desperately needed a large city grant similar to that bestowed upon the Mission.

In late 1935, the VON decided to take matters one step further. At the end of a more general discussion about ways in which the Local Branch could increase their workload and income, the Board empowered its President to discuss a possible take-over of the Scott Mission with Mr. Peter Lowe of the Winnipeg Foundation. If he agreed, and if there were no legal obstacles to this initiative, discussions were then to ensue with the Mission's Board.[139] The December minutes of the Mission record that its president, Mrs.

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[138]AM, The Mission papers, MG10, B9, Box IV. Minutes of May 13, 1935.

[139]VON, Winnipeg Branch. Minutes of October 22, 1935.

Robinson, was to attend a "round table conference to be held in Mr. Lowe's office, early in the New Year." [140] The President and members of the VON executive were also to be in attendance. "The outcome of the Conference," added the recording secretary, "should prove of interest to all."[141] Unfortunately, the records of both agencies contain no information about the meeting or whether it was even held.

The financial analysis of the two organizations sheds considerable light on the otherwise inexplicable interest in free nursing that the VON showed during the 1930s. On the face of it, it made no sense for an almost insolvent visiting nursing organization to volunteer to provide free nursing services for the city of Winnipeg. The city Council was not in a position to provide each with a grant equal in size to that received by the Scott Mission. However, closure of the Mission and the transfer of its funding to the VON would have stabilized the latter's financial situation. In 1934, had the VON retained its current grants and received all those allocated to the Mission, it would have been able to maintain its current staff of nurses on full salary and employ five more nurses at the same salary.[142] The combined caseloads, totalling 37,169 visits in 1934 could have been handled by a staff of fourteen nurses if they worked 5 ½ days per week and completed an average of nine visits per day. Although this would have been a challenging proposition,

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[140]AM, The Mission papers, MG10, B9, Box V. Minutes of December 9, 1935.

[141]AM, The Mission papers, MG10, B9, Box V. Minutes of December 9, 1935.

[142]VON, Winnipeg Branch. Minutes of February 1, 1929 and November 14, 1932. This calculation is based on an annual salary of $1350 per annum for each nurse. This was, in fact, the salary for VON nurses in 1932.

it was not impossible.

The VON's gamble failed. No further reference to the takeover of the Mission appears in subsequent minutes of either organizations. The Mission retained sole responsibility for the provision of free nursing care in Winnipeg and sole claim on the city grant provided to support this work. The VON continued to struggle with the logistics of balancing operating expenses with a decreased volume of requests for services, a decreased fee structure, and minimal government grants for the duration of the decade.

From Feminine to Masculine Control: The Impact of Dependence on External Funding on the Administrative Autonomy of the Scott Mission and the VON

For female-administered visiting nursing organizations, one of the unexpected consequences of accepting funding from external sources was the imposition of accounting procedures and service delivery policies that may not have been, at least initially, congruent with those already in place within the agency. Grants from organized charities and the city and provincial governments created administrative obligations for the Boards of both the Mission and the VON. To a large degree, the working relationships between these all-female boards and the male representatives of their external funding agencies were cordial. However, the internal operations of both organizations were subtly reshaped by their interactions with these publicly funded, male dominated organizations. The degree to which masculine bureaucracies changed the administrative practices of these two female-led agencies differed. The Scott Mission, exemplifying the "tenacity of evangelical women" in resisting innovations which portrayed their work as an old

fashioned relic of another age, was far less transformed by these relationships than was the VON.[143]

Dependence on civic grants obligated the Scott Mission's Board to conform with any reporting or fiscal guidelines imposed by the city of Winnipeg. However, these were apparently not onerous. Monthly reports from the Mission's two district nurses, Eliza Beveridge and Eliza Lamont, appear in the Market, Licence & Health Committee Minutes between 1904 and 1905.[144] These were briefly succeeded by reports by the Mission's recording secretary, Louise Minty, but after 1907, no further reports were received by the Committee.[145] The only other adjustment that the Mission made to conform with the policies of its external funding bodies was to change their fiscal year to coordinate with that of the city. This was done in 1915. Otherwise, the city made no administrative or organizational demands on the Mission. The presence of A. J. Douglas, Winnipeg's medical health officer, on the Mission's Advisory Board and at annual meetings, and the statistics contained in the Mission's Annual Reports appear to have satisfied the city's need for information about the Mission's work.

In contrast, the VON reshaped their legal and financial practices on several occasions in direct response to the social, political and bureaucratic environment in which

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[143]Kunzel, *Fallen Women, Problem Girls,* 169.

[144]CWA, Market, Licence & Health Committee. Minutes of the 1904-1908; Minutes of 1905-1908. Communications from these individuals were documented at almost every meeting.

[145]CWA, Market, Licence & Health Committee, Minutes of 1905-1908. Communications from Minty were documented at almost every meeting in 1905-07.

they were operating. When they purchased the property at 145 Sherbrook St. in 1910, they applied for a letter of incorporation so that they could hold the property themselves rather than have it held in trust by their all-male Advisory Board.[146] Adjustments to conform with the business practices of the Metropolitan Life Insurance Company, as previously discussed, were also made during their second decade of service in Winnipeg. The VON operated without government grants until 1911, when they received a $500 grant from the City of Winnipeg.[147] However, as was the case with the Mission, the city placed no significant obligations upon the Board in return for its financial support.

The most significant transformation in the operations of the VON occurred when they joined the Federated Budget Board's unified fund raising campaign in 1922. In return for the generally less than adequate financial support received from the Federated Budget Board, the VON was prohibited from conducting any fundraising campaigns on its own.[148] The Board was thus forced to abandon its lucrative sale of Christmas stamps, which in 1921 had netted them a profit of $5782.96. In November of 1922, Mayor Duncan informed the Board that it also could not accept an offer by a theatrical group to

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[146]VON, Winnipeg Branch. Minutes of September 14, 1910. The Local Branch was formally incorporated in April 1911, and the deed for the house was transferred from their Trustees to the Board. Minutes of April 12, 1911.

[147]VON, Winnipeg Branch. Minutes of November 8, 1911.

[148]VON, Winnipeg Branch. Minutes of November 15, 1922 and October 16, 1926. The minutes reveal that the Federated Budget's financial support was generally less than that requested by the VON. For example, in 1923, the Winnipeg Branch received just over $15000 from the Federated Budget. It had requested $25,000. In 1927, it received $12700 rather than the $18140 it had set out in its budget.

mount a benefit performance for the VON because "it would not be in the interest of the Fed. (sic) Budget campaign."[149]

The Federated Budget Board's control of the VON's budget went much deeper than the suppression of fundraising activities, however. Representatives of the Federated Budget Board also examined how the VON managed its financial matters and allocated its fiscal resources. In 1925, when the VON's financial situation was extremely precarious, the Federated Budget Board refused to provide them with more money. Instead, it suggested that patients who could only pay the minimum fee be turned over to the Scott Mission. At the same meeting, the Federated Budget Board gave the VON "permission" to fundraise in outlying municipalities such as St. Vital. Instead, the VON President asked the Board for "suggestions for raising money quietly for the deficit." Each member agreed to personally approach other interested individuals with a goal of raising at least $25.00 per member before the end of June.[150] For several years, the VON conducted rummage sales in St. James to evade the Federated Budget's control of fundraising for charitable purposes.[151]

The VON was also obligated to consult with the Federated Budget Board prior to making major financial decisions. In 1937, the Board sought the permission of the

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[149]VON, Winnipeg Branch. Minutes of November 15, 1922.

[150]VON, Winnipeg Branch. Minutes of March 18, 1925.

[151]VON, Winnipeg Branch, *The Twenty-fourth Annual Report,* (1925) 13; *The Twenty-fifth Annual Report*, (1926) 13; *The Twenty-sixth Annual Report*, (1927) 15; *The Twenty-seventh Annual Report*, (1928) 13; *The Twenty-eight Annual Report*, (1929) 15; *The Twenty-ninth Annual Report*, (1930) 13; *The Thirtieth Annual Report*, (1931) 30.

Community Chest (formerly the Federated Budget Board) to purchase a second car for the nurses and to raise some of the necessary funds themselves. They were given permission to do both, but fundraising was restricted to social activities. No door to door canvassing was allowed. The Board promptly organized a Bridge party at the Fort Garry Hotel, netting a profit of $420.25.[152]

Control of the city's charitable donations also enabled the male-dominated Federated Budget Board to shape charity work to suit their priorities. These did not necessarily match the priorities of their female-led member organizations.[153] The VON had direct experience with this problem. Their serious financial problems in 1925 were a direct result of the Federated Budget Board's unsuccessful charity campaign and its decision to give priority to child welfare programs. Only agencies directly involved in child welfare work received increases in their 1925 allocations.[154] As a result, the VON was allocated a much smaller grant than they had requested. The state's interest in nation building had taken precedence over services dedicated to the care of childbearing women and the sick.[155]

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[152]VON, Winnipeg Branch. Minutes of September 15, 1937 and October 20, 1937.

[153]Gale Wills argues that the organized charity movement, particularly the Federated finance schemes and their successors, was a strategy by which the male business community exerted control over work of charity workers, who were primarily female. See: Wills, *Marriage of Convenience.*

[154]VON, Winnipeg Branch. Minutes of February 18, 1925.

[155]For a discussion of the importance that children played in the development of the modern state, see: Comacchio, *Nations are Built of Babies*; Davin, "Imperialism and Motherhood;" Sutherland, *Children in English-Canadian Society.*

Despite the increased level of interaction with male dominated public sector charitable and health care organizations, the VON resisted male intrusions into the official management structure of their organizations. In 1925, Gertrude Hall, Chief Superintendent of the VON suggested to the Winnipeg Branch that it include men on their Board. This suggestion was stiffly rebuffed by the Board, who stated that "it was out of the question asking business men to come on the board and attend the monthly meetings."[156] Since Board meetings were generally held midweek in the late morning, it was undoubtedly true that business men would find it difficult to attend. However, no consideration was given to rescheduling meetings to the evening. Clearly, few female members of the Board would have found evening meetings convenient. Their domestic duties, including meal preparation and the supervision of children, would have taken precedence at that time of the day.

All of these experiences, although frustrating at times, gave the VON considerable experience in the give and take of political and business affairs, and honed their bargaining and lobbying skills. These skills stood them in good stead during the 1940s, when efforts to streamline and rationalize the whole public health system in Manitoba began in earnest.

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[156]VON, Winnipeg Branch. Minutes of December 22, 1925 and February 17, 1926.

Conclusion

The origins of visiting nursing, both in Winnipeg and elsewhere, are intimately linked with the idea of charity. At that time, the Canadian state neither expected nor was asked to undertake responsibility for the health care of individuals and families. Those who could afford to pay for their own health care did so. Those who did not have the financial means to make these arrangements either went without care or, if sufficiently desperate or destitute, turned to local governments or charitable organizations for assistance. The inability of charitable organizations such as the VON and the Scott Mission to continue their operations without significant financial support in the form of grants from government and organized charity soon became abundantly clear. The Mission's dependence on public funding was acknowledged early in its existence by the city of Winnipeg, which provided large grants to support its operations.

The VON was initially more able to go it alone. However, the organization's capacity to sustain itself financially through the collection of patient fees was tenuous from its very beginnings, and eroded significantly throughout the period under study. Revenues from fundraising, which initially bridged the gap between patient fees and actual operating expenses, virtually disappeared once the VON joined the Federated Budget Board in 1922. Like the Mission, the VON also found that long term survival could only be assured through the securing of substantial external funding from the local and provincial governments. The constant demands from male professionals and bureaucrats that the VON bring its budgetary practices and nursing programs in line with

externally determined guidelines reveals the instability of the gendered assumptions upon which Winnipeg's early public health system was founded. By the end of this era, the organization of visiting nursing services to provide bedside nursing care to women and children was no longer perceived as the exclusive domain of women. A greater emphasis on organized charity and the early emergence of the welfare state destabilized women's authority over the visiting nursing organization they had founded. Similarly, the visiting nurses employed by the VON were perceived by Winnipeg physicians as a threat to their professional and financial status. In order to constrain the scope of practice of visiting nursing, and subordinate their work to medicine's professional project, Winnipeg physicians created regulatory strategies to ensure that the VON's visiting nurses worked under their direct supervision. Thus, by 1940, two realities had emerged. One was that public funding was essential to the provision of visiting nursing services in the community. The second was that both female-led organizations had become enmeshed in the patriarchal structures of governments and organized charities.

Chapter 6

Public Health's Other Agenda: The Moral Regulation of Immigrant Women and Children by the Margaret Scott Nursing Mission

Introduction

Many accounts of the public health movement in Britain, the United States, and Canada focus on the positive impact that its programs had on the health of the population. Particular attention is paid to the significant gains in health and longevity attained by the most vulnerable segments of society, including women, children and the poor. Although it is difficult to dispute the assertion that public health alleviated unnecessary suffering and premature death, other historians have balanced these narratives of benign progress with a more searching analysis of public health's covert agenda. Public health programs divided populations into two distinct groups: those who organized and delivered interventions, and those who, in the opinion of the former, required them. The recipients of public health interventions were subjected to the scrutiny and moral judgement of those who provided them. Beyond the compassion and humanitarianism lay another agenda. Elite and middle class social reformers sought to refashion potentially dangerous social subgroups into docile and obedient citizens. "Fallen" women, "wayward" girls, helpless infants, "ignorant" mothers, "slovenly" immigrants, and "impecunious strangers" alike became the targets of the public health movement.

The thesis of this chapter is that health care agencies can be instruments of moral regulation. In particular, it argues that visiting nursing agencies such as the Scott Mission were uniquely positioned to operate within this paradigm. Founded and managed by

female social reformers, and staffed by female nurses indoctrinated in the virtues of Western scientific medicine, visiting nursing agencies possessed the power to influence and, indeed, regulate the behaviour and beliefs of the patients they served. By transforming the attitudes and beliefs of the family's primary caregiver, the mother, the family's health practices and social behaviours could be shaped to more closely approximate those of the city's socially-elite English speaking population.

This chapter explores how both the Scott Mission and, to a lesser extent, the VON, in the course of providing visiting nursing services to Winnipeg's poor and immigrant populations, also attempted to regulate and shape the social and moral behaviour of their patients. First, building on the work of Artibise, this chapter argues that a social chasm existed between the Mission's Board of Management and the clients it served.[1] Second, evidence that the Mission's clients and others in similar circumstances were constructed by Winnipeg's social elite as inferior beings is presented and analysed. Third, a case will be made that Winnipeg's social elite established a network of closely integrated governmental and voluntary social service agencies and governmental bodies to both provide services to the "less fortunate" and retain social, economic, and political control of the city. Finally, this chapter argues that elite and middle class women's capacity to share their version of the "ideal society" with their "less fortunate sisters" was grounded in the political and social dimensions of gender.

The chapter will focus primarily on the Scott Mission for two reasons. It was the primary provider of health education and bedside nursing care to Winnipeg's poorest

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[1]Artibise, *Winnipeg: A Social History.*

citizens. Second, more complete documentation of both Board members and patients exists for this agency. The Mission's papers include case Applications for Nursing Attendance and Relief completed on patients visited by its nurses between 1908 and 1921. Demographic data on the Board members, which was extracted from various sources, also covers the years 1904-1921 in order to facilitate direct comparison of the two groups. Discussion of the methodological issues related to the use of case files, and the procedures used to sample the Mission's Applications are found in Appendix 2.

Assimilation, Moral Regulation and Health Care

During the 1970s, Alan Artibise produced a monograph and a series of articles on late nineteenth and early twentieth century Winnipeg. A recurrent subject of his work was the response of Winnipeg's social and political elite to the city's burgeoning population of Eastern Europeans and working class Anglo-Celts. Assimilation and Canadianization, he argued, were central strategies in elite Winnipegers' responses to "the immigrant problem." To support his assimilation thesis, Artibise described how the governmental and voluntary social service agencies created by Winnipeg's elite during this period were part of a larger effort to establish Winnipeg's identity as a Canadian and British city.[2]

In the midst of his analysis of the roles that individual agencies played in the assimilation process, however, Artibise made a remarkable statement about the city's first visiting nursing agency and its participation in the effort to assimilate recent immigrants:

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[2]Alan Artibise, *Winnipeg.* See Chapter 10: The Immigrant Problem: Accommodation, Disease and Economic Adjustment: 177-194 and Chapter 11: The Immigrant Problem: Education and Assimilation: 195-206.

> While the Margaret Scott Nursing Mission attempted to meet the newcomers' physical needs and *was only indirectly concerned with assimilation* [italics mine], the All People's Mission sought to help solve this much broader adjustment problem.[3]

It is difficult to believe that a charitable organization, founded in 1904 in the midst of Winnipeg's most intense experience with immigration and population growth, could avoid the taint of cultural imperialism ascribed to other agencies with which it interacted and cooperated. Artibise may have been beguiled by the myths surrounding the "saintly" Margaret Scott and the Mission which bore her name. However, it is more likely that his methodology, which focussed primarily on a geographic and demographic description of Winnipeg caused him to overlook the potential that a health care agency possesses to participate successfully in a project of cultural assimilation or moral regulation.

Assimilation is a contested term whose meaning shifts in relation to both time and context. In pre-1940 Canada, assimilation was not conceptualized by the dominant Anglo-Canadian culture as the blending of separate but equal peoples. The disdain with which many Canadians of British origins viewed non-English speaking immigrants meant that there was no middle ground for the newcomers.[4] Assimilation required immigrants from non-British countries to conform with British beliefs, values and customs.[5] Anything less threatened the social, political and economic hegemony of Anglo-

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[3]Artibise, *Winnipeg: A Social History*, 192.

[4]For further analysis of the complexities of Canadian attitudes to immigrants and their perspectives on the most appropriate solutions, see, for example: Adamoski, Chunn and Menzies, *Contesting Canadian Citizenship*; Friesen, *The Canadian Prairies*; Roy, *A White Man's Province*; Roy, *The Oriental Question.*

[5]Palmer, *Immigration*, 112-115.

Canadians. "Dirty, frowsy Galicians" and their fellow non-British immigrants could not be allowed to alter the "superior" nature of the British way of life.[6] As R.B Bennett stated in the House of Commons in 1928:

> These people [continental Europeans] have made excellent settlers; they have kept the law; they have prospered and they are proud of Canada, but it cannot be that we must draw upon them to shape our civilization. We must still maintain that measure of British civilization which will enable us to assimilate these people to British institutions, rather than assimilate our civilization to theirs.[7]

It is possible, in these words, to read not only the text of "British superiority," but the sub-text of Anglo-Canadians' anxieties regarding their ability to maintain their culture in a country far from "home" and populated by "foreigners." It is understandable, therefore, that these anxieties would be channelled into efforts to fashion non-British immigrants into obedient Canadian citizens.[8]

If assimilation was thus conceived to be a one-way-street, then the process had to proceed in a particular way. By constructing the British way of life as "normal," the immigrant was positioned as "not normal," "disorderly," "degenerate," or perhaps even "immoral."[9] Direct imposition of British customs, beliefs and values through the

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[6]Palmer, *Immigration*, 45. This phrase was used in an excerpt from the *Calgary Herald*, January 18, 1899, which is reproduced in this book.

[7]Palmer, *Immigration*, 119. R.B. Bennett's June 7, 1928 speech to the House of Commons is reproduced on pages 119-120.

[8]Stoler, *Race & the Education of Desire*. Stoler points out that the nationalist discourses of colonizing nations were based on the principle of exclusion, and drew on the language of racial purity to differentiate the colonizers from the colonized.

[9]Adams, *The Trouble with Normal*; Cooper and Stoler, *Tensions of Empire*; Valverde, *The Age of Light*. See, especially, Chapter 5: "Racial Purity, Sexual Purity, and

mechanisms of social control was likely to be met with resistance. More effective and complete assimilation depended on persuading immigrants to internalize British beliefs and customs, and thus assimilate themselves. Assimilation to Canadian society was therefore best accomplished through the process of moral regulation.

Moral regulation, states Alan Hunt, occurs when "some social agents problematise some aspect of the conduct, values or culture of others on moral grounds and seek to impose regulation upon them." It is inspired by "the passionate conviction that there is something inherently wrong or immoral about the conduct of others."[10] Moral regulation is decentred and naturalized. In its most effective form, it works within the individual who internalizes discourses and practices of the elite and actively seeks to conform to these standards.[11] Normalization is limiting, both to individuals and to social groups. It constrains the range of behaviours and beliefs tolerated by society, and it creates intense pressure for conformity and for the suppression of differences. At the same time, it intensifies the hegemony of the elite by masking the means by which their power is exerted over "the other."

Althusser and Gramsci have contributed much to the understanding of how state and voluntary social service agencies impose the will of the dominant social system upon "the other." Drawing on Gramsci, Althusser proposed that hegemony could be exerted

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Immigration Policy."

[10]Hunt, *Governing Morals*, ix.

[11]Adams, "In Sickness and in Health", 119. For a haunting fictional analysis of the impact that internalizing the cultural norms of the British majority might have had on Winnipeg's immigrant community, see: Marlyn, *Under the Ribs of Death*.

through two systems: the Repressive State Apparatus and the Ideological State Apparatus.[12] Repressive State Apparatuses exert direct social control through government institutions such as the legal system.[13] Ideological State Apparatuses, on the other hand, are frequently part of the private sector. They include voluntary organizations such as child welfare agencies, rescue homes for single, pregnant women, temperance organizations and organizations providing leisure activities for children and youth, such as the YMCA, Scouts and Guides. Although ostensibly not a part of government, voluntary social service agencies are often closely linked with the state. Linkages are forged in several ways, including the provision of government funding to support the work of voluntary agencies.

Middle class women played a unique and powerful role in projects of moral regulation, both directly and indirectly.[14] Many of the anxieties associated with immigration were played out through the guise of protecting women from "alien" immigrant males.[15] In their maternal role as the guardians of morality in both the domestic and public spheres, elite and middle class women both participated in projects

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[12]Brantlinger, *Crusoe's Footprints*, 92-93.

[13]For an example of how the legal system is used in the process of moral regulation, see: Rose and Valverde, "Governed by Law?"; Strange and Loo, *Making Good.*

[14]Koven and Michel, "Womanly Duties," 1088; Hunt, *Governing Morals*, 1-3.

[15]See, for example: Dua, "Racializing Imperial Canada," 71-85; Mar, "The Tale of Lin Tee," 109-110; Roy, *A White Man's Province*, 14-15, 17; Roy, *The Oriental Question*, 43-44.

of moral regulation and put them on the political agenda.[16] In a society where gender was both "a primary way of signifying relationships of power" and a means to establish and stabilize class relationships, women were uniquely positioned to transmit Anglo-Canadian values and beliefs to non-English speaking immigrants.[17] Thus, Anglo-Canadian women, although subordinate to British-Canadian males, held power over immigrant men and women.[18] Missionary and social reform work amongst the immigrants was conceived as a maternal calling because it emphasized education and it conceptualized those to be educated as childlike or dependent.[19] Although they could not interact directly with immigrant males, lest these interactions lead to accusations of impropriety, they could and did organize projects to "uplift" their wives and sisters.

Traversing The Social Divide: Winnipeg In The Second Phase Of The Modern City

The continuities between the experiences of colonial societies in Asia, Africa, and British Columbia where the colonized were primarily non-Caucasian, and western Canada, where the colonized were primarily Caucasian but racialized immigrants from eastern and southern Europe, are compelling. Both the Scott Mission and the VON are examples of how organizations founded by elite women can act as agents of moral

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[16]Hunt, *Governing Morals*, 1-3.

[17]Davidoff and Hall, *Family Fortunes;* McClintock, *Imperial Leather*, Scott, *Gender and the Politics of History*, 42, 48.

[18]Huber and Lutkehaus, "Introduction," 18; Perry, "White Women, Race and Immigration," 60-61. These authors situate their analyses in colonies where "white" Europeans colonized "non-white" peoples. In the context of Western Canada, it is more useful to think of these two groups as British and non-British.

[19]Lutkehuas, "Missionary Maternalism," 208-209.

regulation. First, they had significant linkages with the state. Funding to support their work flowed from all three levels of government. Another linkage to the state was forged through the creation of honorary positions within the organization The Lieutenant Governor of Manitoba served as the Mission's honorary patron. The VON also had strong links with the state. The National Order's first President was Lady Aberdeen, wife of the Governor General. Subsequent to her departure from Canada, the wives of successive Governors General were appointed as honorary presidents of the Order.[20] In Winnipeg, the wives of current and past Lieutenant Governors served as Patronesses of VON Winnipeg. Annual meetings were held at Government House, and the chairman for these meetings was often the incumbent Lieutenant Governor. These and other linkages with the state increased the probability that the behaviours, beliefs, and values of the dominant social group would be imposed upon those whom that group wished to dominate.[21]

For the Mission and, to a lesser extent the VON, the primary target of their interventions was immigrant women and children. Although detailed statistics are not available for the VON, its Annual Reports and minutes regularly document that the majority of its patients were women and children. Detailed statistics do exist for the Mission. These confirm that its primary focus was the provision of obstetrical care (Table 6-1).

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[20]Gibbon, *The Victorian Order of Nurses for Canada,* 122.

[21]Adams, "In Sickness and in Health", 118-119; Fingard, *The Dark Side of Life,* 117-118; Valverde, *The Age of Light, Soap, and Water*, 25.

Table 6-1: Categories of Nursing Care Provided by the Margaret Scott Nursing Mission*

Diagnosis	1908		1911		1913		1916		1918		1921		Overall	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Obstetrics**	35	97.2	45	98.7	45	86.5	40	47.6	27	29.0	15	88.2	207	62.5
Medical	0	0	0	0	0	0	15	17.9	15	16.1	0	0	31	9.4
Surgical	0	0	0	0	0	0	3	3.6	4	4.3	1	5.9	10	3.0
Infections	0	0	0	0	0	0	15	17.9	14	15.0	0	0	29	8.8
Influenza	0	0	0	0	0	0	0	0	21	22.6	0	0	21	6.3
Trauma	0	0	0	0	0	0	2	2.4	6	6.5	0	0	8	2.4
Not stated	1	2.8	1	1.3	7	13.5	9	10.7	6	6.5	1	5.9	25	7.6
Total	36	100	46	100	52	100	84	100.1	93	100	17	100	331	100

Source: AM, The Mission papers, MG10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief
* More than one type of care provided in some households
** Obstetrics would include both infant and mother

Not surprisingly, the majority of the Mission's patients were adult females, followed by children (Table 6-2).

Table 6-2: Sex and Age of Patients in Household*

	1908		1911		1913		1916		1918		1921		Overall	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Adult male	0	0	0	0	0	0	4	3.5	9	8.0	17	37.8	30	6.2
Adult female	36	68.7	46	68.7	52	70.3	60	52.6	56	50.0	17	37.8	267	55.5
Child	0	0	0	0	0	0	12	10.5	21	18.8	0	0	33	6.7
Infant	34	31.3	21	31.3	22	29.7	38	33.3	21	18.8	11	24.4	146	30.4
Unknown	0	0	0	0	0	0	0	0	5	4.5	0	0	5	1.1
Total	70	100	67	100	74	100	114	99.9	112	100.1	45	100	481	99.9

Source: AM, The Mission papers, MG10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief
* More than one patient identified in many households.

Both the Scott Mission nurses and Board members used their socially sanctioned power to enter the homes of the patients they served. Once inside, their interactions with those they sought to regulate had far-reaching consequences. The lack of cleanliness, crowding

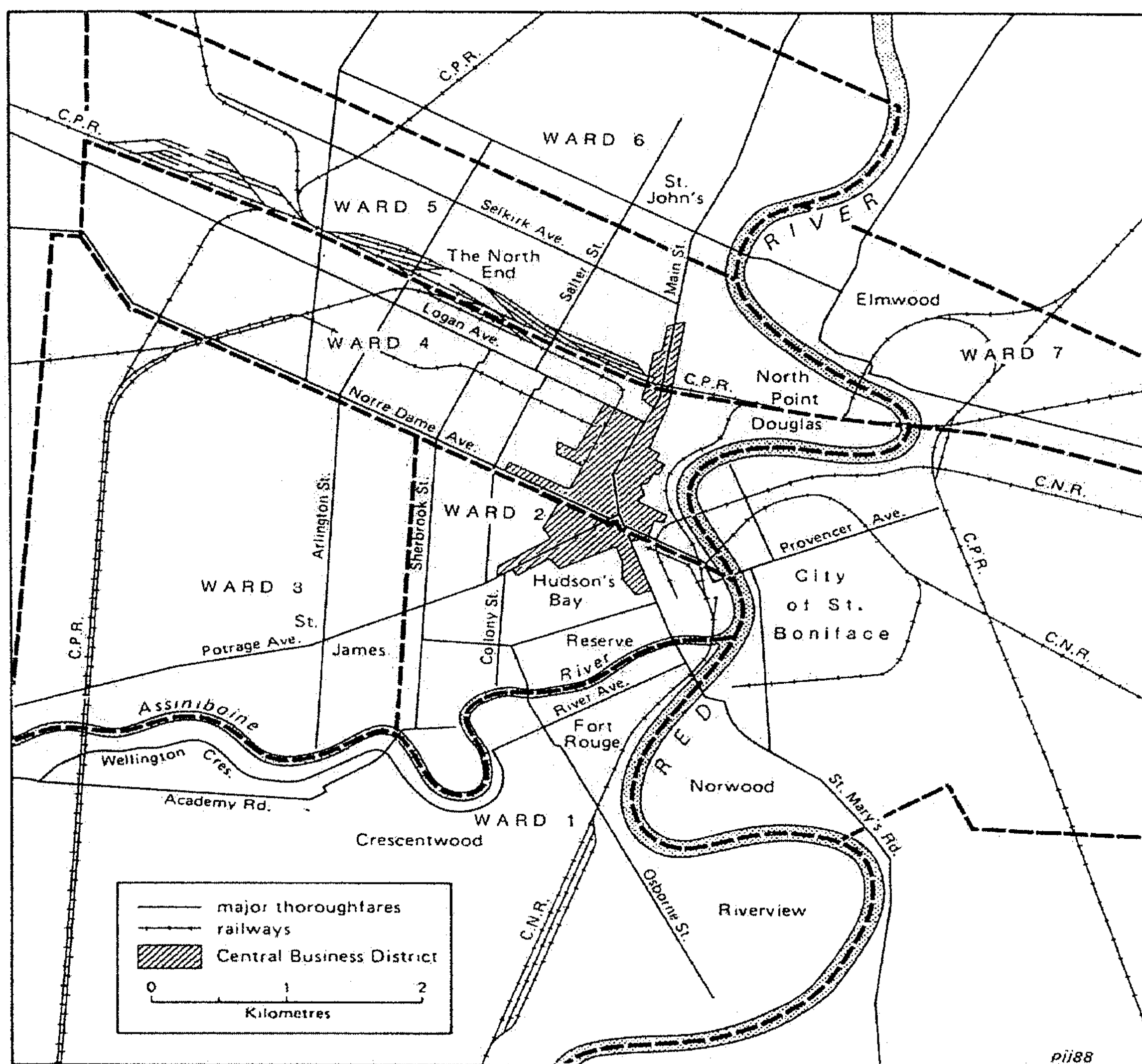
and alien behaviours that elite women and visiting nurses observed in Winnipeg's immigrant districts and in the homes of their patients were constructed as moral problems for which moral solutions were required.

One way of delineating the chasm which divided Winnipeg's elite from its poor and immigrant populations is to examine the geographic distribution of the two groups based on variables such as income. Alan Artibise's detailed description of the civic/political spatial characteristics of pre-First World War Winnipeg is a useful basis for this analysis. The city was originally divided into four wards but by 1914 it had adopted a seven ward system that reflected its evolution from a compact, relatively undifferentiated settlement to a centre city with more distant suburbs. Mapping the variables of ethnicity and religion, Artibise traced the development of a "series of self-contained enclaves" created in response to the rapid influx of Eastern European immigrants.[22] Wards 1 and 2 were the primary residential areas for Winnipeg's social elite. Ward 1 included the affluent south Winnipeg suburbs of Crescentwood, River Heights and Fort Rouge. Ward 2, located in central Winnipeg, included an older, but still affluent neighbourhood in an area north of the Assiniboine River, east of Colony Street and south of Portage Avenue. Ward 3, although primarily a middle to working class district located west of Colony Street, north of the Assiniboine River and south of Notre Dame Avenue, also included the exclusive neighbourhood of Armstrong's Point. Ward 4 included the commercial, industrial and residential neighbourhoods north of Notre Dame Ave and south of the CPR tracks. Wards 5 and 6 were located in Winnipeg's North End. Ward 7, commonly known

[22]Artibise, *Winnipeg: A Social History*, 148.

as Elmwood, was a working class neighbourhood located east of the Red River and north of the Town of St. Boniface.

Figure 6-1: Winnipeg Ward Boundaries and Neighbourhoods, c. 1919[23]



[23]Hiebert, "Class, Ethnicity and Residential Structure," 61.

Winnipeg's elite class was drawn almost exclusively from Anglo-Celtic Protestants born either in Canada or in Great Britain.[24] Data drawn from the Mission's Board minutes and its Applications for Nursing Attendance and Relief both confirm Artibise's thesis and provide additional evidence of the extent to which wealthy and poor Winnipegers lived in almost complete physical and social isolation from each other. In addition, these findings support the argument that the Mission was a creation of Winnipeg's social elite.

The Mission's Board minutes identify the names and addresses of all board members affiliated with the organization from its inception to its closure.[25] Seventy-four women served on the Board between 1904 and 1921. The affluence of the Mission's founders and its subsequent board members is confirmed by the reported occupations of their husbands. All those whose occupations are known were self-employed or salaried employees in highly skilled and professional occupations (Table 6-3). Seven husbands were listed as millionaires in 1910.[26]

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[24]Artibise, *Divided City*, 303-314.

[25]AM, The Mission Papers, MG 10 B9, Box IV, Board of Management 1904-1928, Box V, Board of Management 1928-1944.

[26]Artibise, "Winnipeg's Millionaires, 1910," 117-180. This chapter is an annotated reprint of an article which appeared in the *Winnipeg Telegram* on January 29, 1910.

Table 6-3: Occupations of Margaret Scott Nursing Mission Board Member's Husbands, 1904 - 1921

Occupation	**n**
Business	24
Lawyer/Judge	11
Physician	5
Clergy	1
Banker	1
Professor	1
Total	43
Unknown	31
Total	74

Source: AM, The Mission papers, MG10, B9. Minute Books for 1904-1921; Artibise, *Gateway City*; Bumstead, *Dictionary of Manitoba Biography*; Legislative Library, Biographical Vertical Files, Biographical Scrapbooks; Schofield, *The Story of Manitoba*; University of Manitoba Archives, Winnipeg Elite Files.

Through family connections, Scott Mission Board members, also wielded considerable political power. A total of twenty federal, provincial and civic political offices were held by their husbands (Table 6-4).

Table 6-4: Political Offices Held by Margaret Scott Nursing Mission Board Member's Husbands

Political Office*	**n**
MP	2
MLA	7
Lt. Governor	1
Mayor	1
Alderman	8
School Board	1
Total	20*

Sources: AM, The Mission files, MG10, Minute Books for 1904-1921; Artibise, *Gateway City*; Bumstead, *Dictionary of Manitoba Biography*; Legislative Library, Biographical Vertical Files, Biographical Scrapbooks; Schofield, *The Story of Manitoba*; University of Manitoba Archives, Winnipeg Elite Files.
*Some men held more than 1 political office

In contrast, an analysis of the reported occupations and wages of the families served by the Mission (Table 6-5) reveals that all but six (2.1%) of the sample drawn for this study were employed in low skill and semi-skilled occupations.

Table 6-5: Reported Occupations of Margaret Scott Nursing Mission Patients

	1908		1911		1913		1916		1918		1921		Overall	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Transport/Del.	7	18.4	8	18.2	8	17.0	9	12.2	12	19.0	1	6.7	45	16.0
Construction	6	15.8	8	18.2	5	10.6	5	6.8	5	7.9	1	6.7	30	10.7
Retail	6	15.8	2	4.5	7	14.9	5	6.8	4	6.3	1	6.7	25	8.9
Service/Repair	4	10.5	5	11.3	3	6.4	9	12.2	6	9.5	1	6.7	28	10.0
Agriculture	0	0	1	2.3	3	6.4	1	1.4	1	1.6	0	0	6	2.1
Manufacturing	2	5.3	5	11.3	5	10.6	6	8.1	5	7.9	1	6.7	24	8.5
Labourer	8	21.1	10	22.7	14	29.8	18	24.3	11	17.5	6	40.0	67	23.8
Skilled/Prof.	1	2.6	1	2.3	1	2.1	1	1.4	0	0	2	13.3	6	2.1
Civic Services	1	2.6	1	2.3	0	0	7	9.5	4	6.3	2	13.3	15	5.3
Military	0	0	0	0	0	0	11	14.8	9	14.3	0	0	20	7.1
Domestic	2	5.3	2	4.5	1	2.1	2	2.7	6	9.5	0	0	13	4.6
Seamstress/Tailor	1	2.6	1	2.3	0	0	0	0	0	0	0	0	2	0.7
Total	38	100	44	99.9	47	99.9	74	100.2	63	99.8	15	100	281	99.8

Source: AM, The Mission papers, MG10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief

Most families included in the sample were living in absolute poverty (Table 6-6). For each of the five years sampled for this study, the most frequently reported annual income (the mode) was approximately one-half of that identified as the minimum necessary for subsistence existence for a family living in Montreal during the same time period.[27]

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[27]Copp, *The Anatomy of Poverty*, 31-32, 148. Piva, *The Condition of the Working Class in Toronto,* 171. Copp states that the Canadian Welfare Association Survey of 1926 established $1,101.76 per annum as the absolute minimum living wage for a family of two adults and three children under the age of 14. A subsistence income was set at

Sutcliffe, in his masters thesis, provided a detailed analysis of the cost of basic commodities such as food, fuel, lighting, and rent in Winnipeg during this era. Comparing these costs with the incomes most commonly reported by the Mission's patients reveals shortfalls in the family incomes ranging from $91.00 in 1916 to $535.00 in 1921.[28] In addition, evidence of significant levels of under-employment was found for each of the five years included in the sample. This finding is also corroborated in Sutcliffe's thesis. In 1915, for example, 90% of Winnipeg's bricklayers were out of work, and other trades were also experiencing significant levels of unemployment.[29].

Table 6-6: Reported Incomes and Employment Patterns of Margaret Scott Nursing Mission Patients

Per Annum	1908	1911	1913	1916	1918	1921
Income Range	0-$936.00	0-$1300.00	0-$1965.60	0-$1560.00	0-$1200.00	0-$1620.00
Income Mode	$520.00	$624.00	$780.00	$624.00	$780.00	$520.00
Income Median	$553.80	$624.00	$642.00	$624.00	$884.00	$1196.00
Income Mean	$582.50	$678.20	$730.34	$639.50	$840.55	$1098.67
Families With No Income Documented	15	12	17	29	29	8
Wage Earners Under-Employed	3	3	2	5	0	3

approximately $856.00 per annum. In contrast, the Canadian Brotherhood of Railway Employees set the minimum annual income necessary for a family of five as $2163.42 per annum. Although these calculations were made five years after the time period of this study, the rise of only $260.00 in the reported mode salaries between 1908 and 1918 suggests that incomes for working class families varied little during this time and did not keep pace with inflation. Both Copp and Piva come to this conclusion in their monographs.

[28]Sutcliffe, "Economic Background of the Winnipeg General Strike," 139-141.

[29]Sutcliffe, "Economic Background of the Winnipeg General Strike," 9-27.

Per Annum	1908	1911	1913	1916	1918	1921
Wage Earners Unemployed	7	7	5	7	6	7
Head of Household Dead	0	0	1	5	8	0
Head of Household Deserted Family	2	0	0	0	2	1
Total Number Families	36	46	52	83	75	17

Source: AM, The Mission Papers, MG10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief

Detailed analyses of the places of residence of the Mission's patients and Board members confirm Artibise's thesis that Winnipeg's southwest quadrant was home to Winnipeg's social and political elite. The majority of Board members (67.6%) resided in Wards 1, 2, and 3 (Table 6-7).

Table 6-7: Comparison of Residence s of Margaret Scott Nursing Mission Patients and Board Members: 1904 - 1921

Ward	Patients		Board	
	n	%	n	%
Ward 1	7	2.2	36	48.6
Ward 2	6	1.9	9	12.2
Ward 3	19	6.0	5	6.8
Ward 4	51	16.2	1	1.4
Ward 5	78	24.8	0	0
Ward 6	80	25.4	3	4.1
Ward 7	23	7.3	0	0
Other*	33	10.5	5	6.8
Unsure	18	5.7	15	20.3
Total	315	100	74	100.2

Source: AM, The Mission papers, MG10, Boxes VII-X, Applications for Nursing Attendance and Relief
*Includes outlying Municipalities such as St. Boniface, St. James & West Kildonan

Conversely, the majority of the Mission's patients (73.7%) resided in the working class districts of Wards 4, 5, 6, and 7 (Table 6-8). No Board members resided in Wards 5and 7. Both patients and Board members resided in Ward 2. However, during this period, Ward 2 was in a transitional phase as Winnipeg's elite citizens moved across the Assiniboine River to Ward 1. The stately homes they left behind were subdivided and rented to less affluent citizens.[30] In Wards 3 and 6, specific geographic features separated Board members from the Mission's patients. Board members living in Ward 3 resided in Armstrong's Point. Despite its proximity to working and middle class areas of West Winnipeg, the narrow width of this area's north boundary discouraged all but the most intentional of commuters from entering. Board members residing in Ward 6 were located in a small affluent neighbourhood immediately adjacent to St. John's Cathedral.

Table 6-8: Residences of Margaret Scott Nursing Mission Patients

Ward	1908		1911		1913		1916		1918		1921		Overall	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ward 1	1	2.6	1	2.2	1	1.9	2	2.4	1	1.3	1	5.6	7	2.2
Ward 2	1	2.6	2	4.3	0	0	2	2.4	1	1.3	0	0	6	1.9
Ward 3	4	10.3	1	2.2	3	5.8	4	4.7	5	6.7	2	11.1	19	6.0
Ward 4	9	23.1	9	19.6	7	13.5	19	22.4	6	8.0	1	5.6	51	16.2
Ward 5	9	23.1	13	28.3	15	28.8	16	18.8	21	28.0	4	22.2	78	24.8
Ward 6	4	10.3	12	26.1	13	25.0	31	36.5	18	24.0	2	11.1	80	25.4
Ward 7	3	7.7	1	2.2	3	5.8	4	4.7	10	13.3	2	11.1	23	7.3
Other*	6	15.4	6	13.0	5	9.6	7	8.2	4	5.3	5	27.8	33	10.5
Unsure	2	5.1	1	2.2	5	9.6	0	0	9	12.0	1	5.6	18	5.7
Total	39	100	46	100	52	100	85	100	75	100	18	100	315	100

Source: AM, The Mission papers, MG10, Boxes VII-X, Applications for Nursing Attendance and Relief
*Includes outlying Municipalities such as St. Boniface, St. James & West Kildonan

[30]Artibise, *Winnipeg*, 155.

These stark differences in income and place of residence have psychological as well as material implications. Indeed, moral regulation and the construction of the normal are located in the psychological dimensions of material differences. In their analysis of the physical and psychological dimensions of the modern city, William Sharpe and Leonard Wallock propose that "over the past two centuries, the conception of the city as a physical entity has gradually yielded to one based on intangible relationships."[31] This challenges the historian to move beyond mere description of geographic and demographic contours and to conceptualize the city as a text consisting of signs and symbols whose meanings are simultaneously multi-dimensional and contested. In 1904, Winnipeg was exiting the first phase of the modern city, that of a concentrated, intermixed human settlement, and entering the second phase characterized by a centre city with a suburban ring.[32] In a pattern consistent with mid-nineteenth century Manchester and London, one of Canada's fastest growing cities segmented itself along economic, ethnic, religious, and class lines.[33]

For those who aspire to "read" Artibise's divided city, delineating the geographic, economic, political, and spatial contours of its neighbourhoods is but the first step in tracing Winnipeg's psychological dimensions: "The city we seek conditions the city we

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[31]Sharpe and Wallock, "From 'Great Town' to 'Nonplace Urban Realm,'" 1.

[32]Sharpe and Wallock, "From 'Great Town' to 'Nonplace Urban Realm,'" 11.

[33]Artibise, "Divided City," 309. For a description of the city of Manchester in a similar stage of development, see: Engels, *The Condition of the Working Class,* 45-54.

will find."[34] What city did Winnipeg's British-Canadian elite seek, and what psychological space did the city's poor and immigrant populations occupy in the city that they found?

One city sought by Winnipeg's elite was a metropolis which would rank as Canada's foremost commercial and industrial hub. Winnipeg's unprecedented growth in the period preceding the First World War was fuelled by the opening of the Canadian west. Agricultural and industrial development in the prairies positioned it as the east-west conduit through which flowed all the commodities necessary for the agricultural and industrial expansion of western Canada. In elite citizens' vision of Winnipeg as a modern metropolis, recent immigrants were positioned as a human commodity to fuel capitalist expansion. Indeed, leading Winnipeg businessmen who spoke at the public meeting to establish the Scott Mission placed a dollar value on a new immigrant and used this as justification for focussing their efforts on saving the lives of already arrived immigrants rather than bringing more newcomers to the city. Reporting on the public meeting of May 12, 1904, the *Manitoba Free Press* reported:

> Mr. W. S. Evans was next called upon and spoke at some length on the fact that apart from the humanitarian aspect of such work, it might well be considered from its utilitarian standpoint. "A life saved was certainly as good as a life imported."[35]

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[34]Sharpe and Wallock, "Reading the Modern City.", 9.

[35]*Manitoba Free Press*, May 27, 1904. Similar sentiments were published in the *Winnipeg Telegram* on May 26, 1904. William Sanford Evans was, in 1904, editor of the *Winnipeg Telegram*. In 1905, he became Mayor of Winnipeg and went on to sit as a Conservative MLA in the Manitoba Legislature. D.W. Bole was the founder of a national pharmaceutical company. He represented Winnipeg as a Liberal MP in the House of Commons until 1911. James Henry Ashdown was one of Winnipeg's most wealthy and

Another Winnipeg sought and found in the imaginations of Winnipeg's elite was a city of danger, disorder and, contagion. Proud as elite Winnipegers were of their sprawling, dynamic city, they feared its dark heart. Their exodus from the centre of the city began in the late 19th century when the establishment of a major rail yard by the Canadian Pacific Railway brought heavy industry, increased traffic, and the first influx of 'foreigners' to the formerly wealthy neighbourhood of Point Douglas.[36] Many settled in Ward 2, the new neighbourhood established in the Hudson's Bay Company Reserve west of Main Street and south of Portage Ave. In the early 20th century, elite Winnipegers again moved south across the Assiniboine River to Fort Rouge, Crescentwood and River Heights. This time, their exodus was motivated by the expansion of the business district in the vicinity of Portage Ave. and by the fear of typhoid fever.

The risk of contracting typhoid fever was both imagined and real.[37] Sporadic outbreaks of typhoid had occurred in the city on a regular basis since the 1880s. However, a crisis occurred in 1904 when two serious fires on October 10 and December 28 depleted the artesian wells and forced the city to pump water directly from the Assiniboine River into the water mains. Within two weeks of each fire, serious outbreaks of typhoid fever

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influential businessmen. His business empire stretched from Winnipeg west to the Rockies. He was one of the 19 men identified by the *Winnipeg Telegram* on January 29, 1910 as being a millionaire, and served as Winnipeg's Mayor in 1907 and 1908. Bumstead, *Dictionary of Manitoba Biography*, 10, 28, 78.

[36]Morton, *Manitoba: A History*, 263.

[37]Artibise, *Winnipeg: A Social History,* 231. The "distant menace" of typhoid fever in Wards 4 and 5 was, in the words Dr. Jordan, a consultant retained by the city in 1904 to recommend possible solutions to the typhoid outbreaks "likely sooner or later to involve even distant districts."

occurred in Winnipeg's affluent districts. Ward 2, the district in closest proximity to the fires, was particularly affected.[38] Ward 1, with its newer homes, the newest in water and sewage connections, and its even greater distance from Wards 4 and 5 must have been an alluring option for the concerned citizens of Ward 2.

Winnipeg's southern suburbs created both physical and psychological separation within the city. Central Winnipeg and the North End became *terra incognita* to Winnipeg's elite community. It seemed an unfamiliar, almost impenetrable terrain where debauchery and riotous living threatened the moral purity of the entire city. This sentiment is vividly conveyed in Ralph Connor's description of a Galician wedding celebration in Winnipeg's North End.

> [W]hile respectable Winnipeg lay snugly asleep under snow-covered roofs and smoking chimneys, while belated revellers and travellers were making their way through white, silent streets and under avenues of snow-laden trees to homes where reigned love and peace and virtue, in the north end and in the foreign colony the festivities in connection with Anka's wedding were drawing to a close in sordid drunken dance and song and in sanguinary fighting.[39]

For the "good folk" of south Winnipeg, the city's North End was a place where only the most pious and courageous might tread.[40]

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[38]Artibise, *Winnipeg: A Social History,* 207-222, 227-235.; Artibise, *Gateway City,* 179-190.

[39]Connor, *The Foreigner,* 87.

[40]Connor, *The Foreigner*, 81; Williams, "The Metropolis and the Emergence of Modernism," 17, 13-23. Williams identifies the third theme of the modern city as the impenetrable city and describes the emergence of the urban detective (e.g.: Sherlock Holmes) as representing "a recurrent image of the penetration by an isolated rational intelligence of a dark area of crime which is to be found in the otherwise . . . impenetrable city."

However, inspired by the example of Margaret Scott, the city's beloved missionary, Winnipeg's elite women set out to establish a presence in the city's "foreign quarters." In 1904, Mrs. A.M. Fraser issued an invitation to "the different churches in our City" (all Protestant) to send two lady delegates to attend a meeting in the drawing rooms of her Fort Rouge home to discuss a "Proposed Union Nursing Mission for Winnipeg." In words reminiscent of Britain's great social reformers, Fraser prefaced the specific details of the proposed meeting by stating:

> It has for sometime past been felt by those who are specially interested in "How the poor Live" that with our City's rapidly increasing population and the crowded condition of its poorer homes, an institute in the form of a Nursing Mission (such as we hear of in Toronto and other cities) would be an incalculable benefit.[41]

Once the Mission was organized, a safe base of operation had to be established. A suitable house was purchased at 99 George St., located in Ward 5 east of Main St. and a few blocks south of the CPR line that separated the city's "unfashionable . . . cluster of little black shacks" from the silent white streets where "the good folk of Winnipeg lay snug and warm in their virtuous beds."[42] The Board held its first meeting "in the society's

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[41]AM, The Mission papers, MG 10 B9, Box IV, Board of Management. Mimeographed typed letter on 8 ½ x 11 paper pinned into the front of the Nov 8, 1909 - October 10, 1910 Minute book. See also: Booth, *In Darkest England and the Way Out;* Mayhew, *London Labour and the London Poor*. Both authors pioneered the methodologies of social investigation and systematic collection of data to provide evidence to support their arguments that the poor were not entirely to blame for the circumstances in which they were to be found. An excellent review of the impact of the writings of Mayhew, Booth, Engels and others can be found in: Stallybrass and White, *The Politics and Poetics.* See, in particular, Chapter 3,"The Sewer, The Gaze and the Contaminating Touch" 125-148.

[42]Connor, *The Foreigner,* 13, 87.

home" on October 14, 1905.[43] Monthly Board meetings continued to be held there until the Mission's closure in 1943. The house at 99 George St. became, in the psychological landscape of its founders and supporters, an outpost of civilization in a foreign land. It was to 99 George St. that "the ladies of the Board" invited their social equals to visit them on the first Saturday afternoon of each month in order to interest them in the Mission's work.[44] "The Home" was the residence for the nurses employed by the Mission. And it was from "the Home" that both nurses and Board members ventured forth on their visits to the Mission's clients in "the foreign quarters." The Scott Mission was, in fact, the domestic version of "woman's work for woman" in the foreign missions of China, Korea, Africa, or India.[45]

Constructing "The Foreigner"

Differences in income and place of residence were only two aspects of the chasm between the Scott Mission's founders and the patients they served. Even more compelling were differences in language, religion, and customs. These created significant tensions

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[43]AM, The Mission papers, MG 10 B9, Box IV, Board of Management, Minutes of January 14, June 10 and October 13, 1905. Prior to this date, the Mission had rented a house on Pearl St. near McDermot Ave.

[44]AM, The Mission papers, MG 10 B9, Box IV Board of Management. Minutes of November 11, 1905. " It was decided that the Home should be thrown open to the public on the 1st Sat. Aftn. of the month." This would be for publicity rather than fundraising purposes, since the by-laws of the Mission expressly forbid direct solicitation of funds from individuals.

[45]For a discussion of the motivations underlying women's missionary work, both domestic and in the foreign mission fields, see: Huber and Lutkehaus, "Introduction: Gendered Missions At Home and Aboad"; Robert, *American Women in Mission*, 125-188.

between the two groups. In the Winnipeg imagined by its social elite, the city was a bastion of Anglo-Celtic culture positioned on the margins between an older but similar "civilization" to the east and the barbarism of the yet untamed hinterland to the west. To construct this city, significant challenges loomed large. The most pressing was the Canadianization of the rapidly increasing population of Eastern European immigrants.

The extent to which Winnipeg's "Britishness" was threatened by the presence of large numbers of "foreigners" is documented in the work of Artibise and others.[46] This evidence is confirmed by data found in the Mission's Applications. Part of the patient information documented was the family's nationality and religion. Of the 265 patients for whom nationality was documented, 60.8% were born in non-English speaking countries; primarily in Eastern Europe (Table 6-9, Table 6-10).

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[46]Artibise, *Winnipeg, A Social History*; Artibise, "Divided City"; Artibise, *Gateway City*; Morton, "The Historiography of the Great West," 46-59; Rea, "The Roots of Prairie Society," 40-55. Both Morton and Rea identify the arrival of settlers from Ontario in the 1880s as the critical event which solidified Winnipeg's identity as a British (and therefore Canadian) city. The challenge for the Anglo-Celtic majority was to forge a single, British society from the multi-cultural, multi-ethnic population which resided in Winnipeg soon after the turn of the 20th century.

Table 6-9: Nationalities of Margaret Scott Nursing Mission Patients and Comparisons to Census Data on Winnipeg's Population Composition

Nationality	1908		1911			1913		1916			1918		1921	
	n	%	n	%	Cen	n	%	n	%	Cen	n	%	n	%
English	6	15.4	7	15.2	31.2	14	26.9	13	15.3	35.1	16	21.3	1	5.6
Scottish	6	15.4	1	2.2	19.0	5	9.6	13	15.3	19.3	4	5.3	0	0
Irish	1	2.6	1	2.2	11.4	3	5.8	2	2.4	11.9	3	4.0	2	11.1
Other British	0	0	1	2.2	0.7	2	3.8	0	0	0.7	1	1.3	0	0
Canadian	7	17.9	4	8.7		3	5.8	4	4.7		9	12.0	2	11.1
American	0	0	1	2.2		0	0	0	0		1	1.3	0	0
Scand/Iceland	2	5.1	2	4.3	3.6	1	1.9	1	1.2	3.6	5	6.7	1	5.6
German	2	5.1	6	13.0	5.7	4	7.7	5	5.9	3.5	0	0	1	5.6
Aust./Hung.	0	0	3	6.5	4.5	1	1.9	10	11.8	2.5	9	12.0	2	11.1
Russian/Polish	9	23.1	8	17.4	4.6	5	9.6	27	31.8	5.3	18	24.0	2	11.1
Ukrainian	0	0	0	0	0.7	1	1.9	3	3.5	5.3	3	4.0	3	16.7
French	0	0	1	2.2	2.0	1	1.9	0	0	1.9	0	0	1	5.6
Dutch	0	0	1	2.2	0.4	0	0	1	1.2	0.5	0	0	0	0
Italian	0	0	0	0	0.6	1	1.9	1	1.2	0.8	3	4.0	1	5.6
Asian	0	0	0	0	0.4	0	0	0	0	0.3	0	0	0	0
Jewish	6	15.4	9	19.6	6.6	10	19.2	5	5.9	8.2	2	2.7	1	5.6
Indian/Metis	0	0	0	0	0.1	0	0	0	0	0.1	0	0	0	0
Negro	0	0	0	0	0.1	0	0	0	0	0.1	0	0	0	0
Other	0	0	0	0	7.6	0	0	0	0	0.8	1	1.3	1	5.6
Not known	0	0	1	2.2		1	1.9	0	0		0	0	0	0
Total	39	100.1	46	100	99.2	52	100	85	100	99.9	75	100	18	100

Source: AM, The Mission papers, MG 10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief. Census data is taken from: Artibise, *Winnipeg*, Table 11, page 139.

Table 6-10: Comparison of Immigrants: English Speaking Vs. Non-English Speaking Country of Origin

Country of Origin	n	%
English Speaking	104	36.4
Non-English Speaking	182	63.6
Total	286	100

Source: AM, The Mission papers, MG10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

In contrast, of the known nationalities of the Scott Mission Board, all were born in Canada or Britain (Table 6-11). Of the 34 known birthplaces of Board members (or their spouses), 23 were born in Canada, 10 in the British Isles (including Ireland) and 1 in the United States.

Table 6-11:Known Nationalities of Margaret Scott Nursing Mission Board Members*

Country of Origin	n	%
England	6	18.2
Scotland	3	9.0
Ireland	1	3.0
Canada	23	69.7
United States	1	3.0
Total	34	99.9

Source: AM, The Mission files, MG10, Minute Books for 1904-1921; Artibise, *Gateway City*; Bumstead, *Dictionary of Manitoba Biography*; Legislative Library, Biographical Vertical Files, Biographical Scrapbooks; Schofield, *The Story of Manitoba*; University of Manitoba Archives, Winnipeg Elite Files.
*or, if nationality of member not know, nationality of the spouse.

The Mission's board members and patients were divided by faith as well as nationality. Compared to the population of Winnipeg as a whole, proportionately more Catholics and Jews received services from the Mission. For example, in 1916, Census data indicated that 71% of Winnipeg's population was Protestant, 18% was Catholic and 8.4% was Jewish.[47] In contrast, between 1904 and 1921, 50.3% of the Mission's patients were Protestant, 30.5% were Catholic, and 19.1% were Jewish (Table 6-12).

[47]Artibise, *Winnipeg, A Social History,* 143.

Table 6-12: Religions of Margaret Scott Nursing Mission Patients and Comparisons to Census Data on Winnipeg's Population Composition

Religious Affiliation	1911			1916			1904-1921	
	Mission Patients		Census	Mission Patients		Census	Mission Patients	
	n	%	%	n	%	%	n	%
Protestant	21	45.7	72.7	37	45.1	71.0	150	50.3
Catholic	6	13.0	17.0	30	36.6	18.0	91	30.5
Jewish	15	32.6	6.6	12	15.6	8.4	57	19.1
Total*	42	91*	96.3*	79	97*	97.4*	298	99.9*

Sources: AM, The Mission papers, MG 10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief. Census data is taken from Artibise, *Winnipeg*, Table 13, p. 143.
*Do not total 100% because not all data in Applications for nursing Attendance and Relief or Census data included.

The members of the Board deviated from the norm even more dramatically than did the patients. All known religious affiliations of Board of Management members (38 of 71) were Protestant denominations (Table 6-13).

Table 6-13: Religious Affiliations of Margaret Scott Nursing Mission Board Members

Denomination	n	%
Anglican	21	29.6
Baptist	0	0
Congregationalist	1	1.4
Methodist	5	7.0
Presbyterian	10	14.1
Protestant	1	1.4
Not known	33	46.5
Total	71	100

Source: AM, The Mission files, MG10, Minute Books for 1904-1921; Artibise, *Gateway City*; Bumstead, *Dictionary of Manitoba Biography*; Legislative Library, Biographical Vertical Files, Biographical Scrapbooks; Schofield, *The Story of Manitoba*; University of Manitoba Archives, Winnipeg Elite Files.

The majority of families receiving nursing care from the Mission were relative newcomers to both Canada and Winnipeg. Overall, 87.1% of the patients were immigrants (Table 6-14).

Table 6-14: Immigrant Status of Margaret Scott Nursing Mission Patients

	1908		1911		1913		1916		1918		1921		Overall	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Immigrant	33	91.6	38	82.6	49	94.2	75	89.3	61	81.3	14	82.3	270	87.1
Canadian	2	5.5	4	8.7	2	3.8	2	2.4	9	12.0	3	17.6	22	7.1
Not stated	1	2.8	4	8.7	1	1.9	7	8.3	5	6.6	0	0	18	5.8
Total	36	99.9	46	100	52	99.9	84	100	75	99.9	17	100	310	100

Source: AM, The Mission papers, MG 10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

The average time of residence in Canada and Winnipeg reported by the Mission's patients rose during the period under study. In 1908, the typical Mission patient had lived in Canada for 5.1 years and in Winnipeg for 3.2 years. In 1921, the average length of residence in Canada had risen to 11.6 years and in Winnipeg to 9.6 years (Table 6-15). However, for an impoverished, non-English speaking family, even 11 years of Canadian residence constituted only the bare beginnings of adjusting to life in a foreign culture.

Table 6-15: Duration of Immigrants' Residence in Canada and Winnipeg: Margaret Scott Nursing Mission Patients 1908-1921, in Years

	1908		1911		1913		1916		1918		1921	
	$\bar{x}$*	Mdn**	$\bar{x}$	Mdn	$\bar{x}$	Mdn	$\bar{x}$	Mdn	$\bar{x}$	Mdn	$\bar{x}$	Mdn
Winnipeg	3.2.	2.0	4.2	5.0	3.9	2.8	6.5	5.0	9.6	7.0	9.6	10.0
Canada	5.1	3.0	5.3	5.0	4.9.	3.5	7.5	6.0	11.1	10.0	11.6	10.5

Source: AM, The Mission papers, MG 10, B9, Boxes VII-X, Applications for Nursing Attendance and Relief
*$\bar{x}$ = mean
mdn - median

In response to differences in culture, language, and faith, Winnipeg's elite created both physical and psychological divisions within the city to distinguish themselves from "the foreigners." In the Board members' reports of visits to poor immigrant families, in the reports of the nurses and student nurses, in the testimonies and reports of sister organizations, and in the daily newspapers, the inhabitants of Winnipeg's poorer districts were cast into roles and caricatures that reflected the anxieties, patriarchal attitudes, and pity of those who observed them.

Works of literature also positioned "the foreigner" as an inferior being within the psychological landscape of Anglo-Canadian Protestant Winnipeg. Charles W. Gordon, Presbyterian minister of St. Stephens Church, was an influential supporter of the Mission.[48] As Ralph Connor, best-selling author and spiritual mentor to a generation of English reading Canadians, Americans and Britons, he voiced the anxieties and fears of Winnipeg's elite citizens. It is through Connor's novels that we meet "the foreigner" face to face.

One novel, *The Foreigner: A Tale of Saskatchewan*, is a complex melodrama with several subplots. Two are germane to this analysis. One plot involves the transformation of Kalman from a poverty-stricken Russian boy living in Winnipeg's North End to a mine manager working near the western frontier community of Wakota. The other traces the successful efforts of Brown, a Presbyterian missionary, to bring civilization and

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[48]AM, The Mission papers, MG 10 B9, Box IV, Board of Management, Minutes of May 12, 1904, undated, unnamed newspaper clipping pasted with the Minutes of October 1906, Minutes of October 28, 1905, October 31, 1910, October 1911, October 26, 1912, October 25, 1913.

enlightenment to the inhabitants of a Galician colony near Kalman's mine. Embedded in *The Foreigner* is a hierarchy of "breeds diverse in traditions, in ideas, in speech and in manner of life."[49] At the top of the hierarchy are the English and the Scots. The English are sympathetically represented by three important characters. Of these, Brown, whose career parallels that of Gordon, is the most important. Brown is cheerful, optimistic and wise. He aspires to "teach them [the Galicians] English . . . doctor them . . . teach them some of the elements of domestic science; in short, do anything to make them good Christians and good Canadians, which is the same thing."[50] Brown's neighbour, French, is an English rancher whose tragic disappointment in love has resulted in periodic episodes of alcohol abuse and the neglect of his land. However, his innate nobility enables him to stand up for a just cause and, in the process, redeem himself. Margaret French, "a little lady with white hair and a face pale and chastened into sweetness" is French's sister-in-law and lost love.[51] She resides in Winnipeg, where her work amongst the poor has earned her the title of "an angel." Both her physical appearance and her work suggest that her character was inspired by Margaret Scott.

The Scots, represented by Sergeant Cameron and other minor characters, are a doughty, dour race who created a "rampart of civilization" in the Canadian West.[52] Members of the Russian nobility, as personified by Kalmar and his children Kalman and

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[49]C.W.G. [Charles W. Gordon]. "Preface". *The Foreigner*.

[50]Connor, *The Foreigner*, 253.

[51]Connor, *The Foreigner*, 132.

[52]Connor, *The Foreigner*, 12.

Irma, also receive sympathetic treatment from Connor. Although fraught with the passion inherent in their Slavic blood, their innate nobility and their willingness to embrace Canadian ways earn for them the respect of the novel's leading characters.

The Irish receive slightly less sympathetic treatment. In the character of Mrs. Fitzpatrick and her husband, residents of the North End who "lived in the only house that had been able to resist the Galician invasion," the Irish are portrayed as kindly but simple-minded folk whose memories of past nobility provide a comic foil for their present circumstances. Loquacious, argumentative, and given to fits of passion, the Irish are portrayed as lacking the intellect and drive necessary for true success.[53]

Connor's portrayal of the Galicians is almost entirely negative. Within western Canadian society, he positions them as semi-barbarous threats to civilization.[54] To create this image, he subjects their living standards, their diet and their appearance to the scrutiny of the Anglo-Canadian reader. They are described as "slow witted," "fatalistic," intemperate, improvident, and easily led by unscrupulous members of their own culture.[55] When describing Anka's wedding, Connor observes that: "[a] single beer keg is an object of consuming interest to the Galician and subjects his sense of honour to a very considerable strain."[56] Their only redeeming feature is their willingness to engage in

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[53]Connor, *The Foreigner*. For an example of Fitzpatrick's character development, see Connor's description of her performance as a witness in Kalmar's trial on pages 111-125.

[54]Connor, *The Foreigner*, 35, 108.

[55]Connor, *The Foreigner*, 15, 159, 274.

[56]Connor, *The Foreigner*, 33.

"steady, uncomplaining toil."[57]

"Indians" and "half-breeds." are positioned at the bottom of this hierarchy. They are personified in Mackenzie, French's half Cree, half Scot partner. Connor invests little sympathy in this character, describing him as lethargic, lazy, cunning, savage, and willing to "die for whiskey."[58] Mackenzie's character remains unaltered throughout the novel, signalling to the reader that there is no place for an Indian in the new society envisioned by Connor.

Connor also creates a hierarchy of the Christian faiths. At the top is Protestantism. Kalmar's dying words to Brown reveal its virtues to the reader: "Your religion is good. It makes men just and kind. Ah! religion is a beautiful thing when it makes men just and kind."[59] Slightly less valued is Roman Catholicism. Represented by the kindly and child-like Father Garneau, who is basically a good man unable to make the necessary leap of faith to embrace Protestantism, Roman Catholics are, none-the-less, portrayed as in harmony with the basic precepts of God and Christ.[60]

On the other hand, Orthodox (Greek) Catholicism is represented by the demonic "small, dark and dirty" Father Klazowski.[61] Rather than serve God and his compatriots, Father Klazowski engages in threats and extortion, simultaneously crushing his

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[57]Connor, *The Foreigner*, 14.

[58]Connor, *The Foreigner*, 223, 229, 233, 288.

[59]Connor, *The Foreigner*, 369.

[60]Connor, *The Foreigner*, 338, 240.

[61]Connor, *The Foreigner*, 274.

congregation under his heel and subverting the good work carried out by Brown. Ultimately Klazowski's own people, enlightened and empowered by Brown, French and Kalman, rise up and drive their evil priest out of the community.

In Connor's characters, we discern the shapes and dimensions of "the other" sought and found in the psychological landscapes of Winnipeg's elite citizens. *The Foreigner* simultaneously suggests and reflects their solutions to the "immigration problem." Clearly, the only way to eliminate the threat they posed was to teach them "our ways of thinking and living."[62] This could be most readily accomplished through the education of their children. In *The Foreigner*, Simon Ketzel was able to "slough off his foreign speech and manner of life, and his foreign ideas as well, and become a Canadian citizen" with the assistance of his daughter Margaret. Her attendance at those "greatest of all Canadianizing influences, the school and mission" brought civilization into their home.[63] Once assimilated, the Ketzel family exerted a cleansing and healing influence on others who came in contact with them.

Health care was another tool in the arsenal of the elite. Margaret French's presence in the novel was a clear signal to the informed reader that the work of women such as Margaret Scott was an essential component of the Anglo-Celtic assimilation project. Hospitals and nurses, too, were part of the solution. Under Margaret French's influence, Kalman's sister Irma becomes a nurse and eventually takes charge of Brown's hospital in Wakota.

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[62]Connor, *The Foreigner*, 255.

[63]Connor, *The Foreigner*, 157, 158.

Finally, the rejection of Catholicism is presented as the true mark of the immigrant who has embraced the Canadian way of life. In refusing the offer of confession from the good Father Garneau, Kalman reveals that he has rejected his former faith for that of his mentor Brown:

> I have for some years been reading my Bible, and I have lived beside a good man who has taught me to know God and our Lord and Saviour Jesus Christ. I seek to follow him as Peter and the others did. But I am no longer of the Galician way of religion, neither Greek nor Roman.[64]

At the end of the novel, Connor places the redeemed Galicians in their proper place in Canadian society. Working under the direction of their betters, Kalman, French, and Sir Robert Menzies, the members of the Galician colony find prosperity and transformation as workers in the coal mine established near French's ranch. Their one redeeming characteristic, their willingness to work hard, fashions them as docile and obedient workers and harnesses them to the enterprises of the elite.

Moral Regulation and the State: Creating the Web and Constructing the Normal

Thus far, this chapter has argued that the Mission's founders were drawn from the ranks of Winnipeg's social and political elite, whereas the Mission's patients were amongst the city's poorest and most recently arrived immigrant families. In addition, it has argued that, in the city sought and found by Winnipeg's elite, these "foreigners" represented a potential threat to the prevailing social and political order. On the other hand, as workers, these same "foreigners" were an important asset to a city poised on the brink of unprecedented industrial and commercial expansion. In response to this

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[64] Connor, *The Foreigner,* 339.

dilemma, Winnipeg's Anglo-Canadian elite constructed a complex network of state and voluntary social agencies whose ultimate purpose was to maintain and promote their political and cultural agenda through moral regulation and the construction of the normal.

For elite Winnipegers, construction of the normal focussed on the visible differences between themselves and Winnipeg's immigrant populations. Connor's descriptions of the food, dress, living conditions and customs of Eastern European immigrants provide concrete evidence of the purported "abnormal" social and moral behaviours of this group. Scott Mission Board members and nurses also believed that immorality caused the downfall of many individuals and families served by the Mission. In presenting her description of the work of the district nurse with unemployed men, Isabel Maitland Stewart stated: "These are usually single men, far from home and friends, and from their own or some one else's fault, usually at the lowest extremity financially, yes, and morally."[65] In referring to her work with families, she described some as low and degraded, and others as the victims of incompetence and immorality.

> The people with whom one comes in contact in the district work are all, however, not of the lowest or most degraded. Many new to the country are putting in their preliminary hard time, having had bad luck, illness, loss of work and are stranded for the time being. . . . Others, wives and children, suffer through a lazy, incompetent, drunken or sick husband or father.[66]

Similar descriptions were provided by a student nurse from the Winnipeg General

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[65]*Manitoba Free Press,* November 12, 1904. Isabel Maitland Stewart was an early graduate of the Winnipeg General Hospital School of Nursing. Shortly after her employment as a district nurse, she entered graduate studies at Teachers College, Columbia University. Ultimately, she became head of the nursing program at Columbia and an internationally renowned leader in nursing education.

[66]*Manitoba Free Press,* November 12, 1904.

Hospital. In describing the plight of some families she visited in the course of her district nursing experience at the Mission, she stated: "thriftlessness and neglect were common enough."[67]

The Mission's Board members and nurses also drew attention to the crowded living conditions of the poor and immigrant populations. For example, the practice of taking in boarders to augment meagre wages was regarded by more affluent Winnipegers as a foolish and possibly perilous practice. The Applications for Nursing Attendance and Relief regularly documented that there were boarders present in homes visited by the nurses, that the families themselves were boarders, or that the families visited were residing in the same home as a relative. Although, for the purposes of the Application, this information was gathered to determine the family's income, other evidence suggests that the Mission's Board viewed such living arrangements as dangerous and likely to cause contagion. In her 1910 Annual Report, Board Secretary Louise Minty drew public attention to this problem and explicitly linked it to the high infant mortality and morbidity rates in "certain districts" of the city :

> First we have the unsanitary conditions of crowded tenement and shack. . . . It is then for us who feel the impelling [illegible word] of charity to take heed to our duty as citizens and by proper enactments see to it that such conditions shall not exist. The poor foreigner living in the slums often cannot see how short lived is his policy that makes him ameliorate his poverty in the easiest way, as by taking in boarders often even poorer than he. Even our own English speaking people too often forget how big a price in loss of vitality is paid, for one or two small rooms in an overcrowded, badly designed tenement.[68]

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[67]AM, The Mission papers, MG 10 B9, Box VI, Annual Report of October,1908.

[68]*Winnipeg Telegram,* "Causes of Disease and Poverty", November 1, 1910.

In a bizarre inversion of cause and effect, the headline of the article reproducing Minty's report is entitled "Causes of Disease and Poverty." This, in a nutshell, reveals the elite's belief that the poverty observed in the "foreign districts" was a consequence of disease, rather than the converse. This belief justified their focus on the normalization of appearances and behaviour rather than on changing the root causes of the poverty experienced by Winnipeg's immigrant populations.

What normalizing projects did elite Winnipegers hope that the Mission would accomplish through its visiting nursing service? Clearly, a priority was the imposition of higher standards of personal and household hygiene. Descriptions of the nurses' work confirm that the "gospel of cleanliness" was both embodied by and deployed by the nurses.[69] A nurse's entrance into a family's life was represented as the impetus and inspiration for the physical and spiritual transformation of the interior of the family home.

> Many are the pitiful sights that meet their eyes; a cheerless home; cold, untidy and unclean; emaciated children; a delicate mother and in her arms a little sick child crying from the cold, no fire, no nice warm food, no anything to cheer the heart. But when the neatly uniformed nurse arrives all is quickly changed. A bright fire is soon blazing; the mother is made comfortable, and the wee baby is washed and dressed; warm food is prepared; the house is made tidy; tactful suggestions are given as to better modes of management, while many bright and encouraging words are spoken, elevating to higher things.[70]

The ability to enter directly into the homes of poor and immigrant families is a

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[69] *Winnipeg Telegram*, "Causes of Disease and Poverty", November 1, 1910. Minty used this term in her published report. A similar phrase was used in an unknown newspaper's account of the 1906 Annual Meeting of the Mission. It speaks of the "liberal application of the gospel of cleanliness, when needed."

[70] AM, The Mission papers, MG 10 B9, Box VI, First Annual Report, October 1905, 4-5.

particularly compelling indication that the Mission played an important role in moral regulation. Board members, Margaret Scott, Eliza Beveridge (the Superintendent of Nurses) and the nurses all conducted home visits in the normal course of their duties. Their presence in the home was, in effect, the embodiment of all the agencies and individuals who funded the Mission and/or cooperated with it in the provision of services to this population.

Soon after the Mission's founding, a Visiting Committee was organized by the Board. All Board members were encouraged to visit the homes of patients served by the Mission. Each month, two members of the Visiting Committee consulted with the Superintendent of Nurses and identified "those needing district visitors either in their own homes or in the hospital."[71] This initiative placed the Mission's clients under the direct scrutiny of the social elite. The Mission's public utterances and written reports emphasized the natural, sympathetic, and "unobtrusive" nature of Mission's work.[72] This may have been the Board's perspective of district visiting, but it is difficult to imagine that this sentiment was always shared by the recipients of these visits.

The Board minutes reveal that Visiting Committee members were not always unobtrusive once entry to a patient's home was gained. Board members could, and did intervene if they encountered situations that were not in keeping with their standards. The May 13, 1907 minutes record that "Mrs Stidston . . . gave a most interesting account of an underfed, undersized badly fathered little boy whom she had taken into her home and

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[71]AM, The Mission papers, MG 10 B9, Box IV, Minutes of January 13, 1908.

[72]AM, The Mission papers, MG 10 B9, Box V, *Annual Report*, 1910, 3.

'mothered' with most gratifying results."[73] In March of 1908, Stidston reported that "an effort was being made by Mrs. McBain who has charge of little Jack to legally adopt him and as they anticipated some trouble and the Board was asked if they would stand by her and assist if necessary - which was assured."[74] Surveillance could extend over several months or even years. Mr. and Mrs. W. appear to have received regular visits from Board members for at least three years.[75] The perplexing case of what to do to assist Miss B., "a cripple of many years standing with no prospect of becoming more than partially cured" pre-occupied the Board for nearly a year. The problem was finally resolved when her home congregation, Grace Methodist, was contacted and requested to look after her.[76]

In at least one instance, surveillance by a Board member was extended far beyond the boundaries of Winnipeg. The Minutes of April 10, 1911 record the following:

> Mrs. Nanton reported that she had seen Mrs. M's people in the Old Country and that they were willing to help if she could be sent home. Mrs. Nanton suggested sending her home about July when able to travel meantime Mrs. Nanton is doing most of the looking after the whole family.[77]

Evidently, for some "impecunious strangers whose homes were invaded by illness," the

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[73]AM, The Mission papers, MG 10 B9, Box IV, Minutes of May 13, 1907.

[74]AM, The Mission papers, MG 10 B9, Box IV, Minutes of March 9, 1908.

[75]AM, The Mission papers, MG 10 B9, Box IV, Minutes of Nov 12, 1917, June 14, 1920, Sept. 13, 1920.

[76]AM, The Mission papers, MG 10 B9, Box I, Correspondence. Letter to the Secretary of the Board dated Nov. 11, 1910; Box IV, Minutes of Nov. 14, 1908, Jan. 9, Feb. 13, April 10, June 12, Sept. 11, 1911. It is apparent from the tone of these entries that Miss B. would be categorized as one of the "deserving poor."

[77]AM, The Mission papers, MG 10 B9, Box IV, Minutes of April 10, 1911.

misfortunes of the immigrant experience could include being returned to the "Old Country" after allegedly unobtrusive and sympathetic visits from a member of the Mission's Visiting Committee.[78]

Margaret Scott, Eliza Beveridge, and the nurses also subjected the families they visited to the scrutiny of other social service agencies and officials concerned about the indiscriminate provision of relief to poor and immigrant families. Destitute families who applied to the Mission for nursing care were subjected to a means test, in the form of the Application for Nursing Attendance and Relief, during the first home visit. The visiting nurse documented all particulars related to ethnicity, religion, employment, income, and housing arrangements in addition to information about the nature of the illness that had led to the need for medical and nursing assistance. Many of the Applications were completed in two different hands. The first was that of the visiting nurse, who signed as the "Investigating Nurse." The remainder of the form, including whatever information the nurse could not obtain during the first interview, was completed by Eliza Beveridge or her replacement. It is both interesting and informative to note that variables such as the family's national origins, immigrant status, religion, and employment status were as carefully documented on the form as was the patient's diagnosis. Beveridge also evaluated the data obtained and either approved or did not approve the Application.[79]

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[78]AM, The Mission papers, MG 10 B9, Box IV. This comment was printed in an unnamed newspaper reporting on the Annual Meeting of October 24, 1906. The clipping was pasted in the Minute Book after the secretary's handwritten minutes of the meeting. The words are those of Louise Minty, Secretary of the Board.

[79]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

Applications 230 and 1857 are examples of situations where the financial circumstances of the family prompted Beveridge to reject the application. In one instance (Application 230), she simply noted that the "case [was] not for us." In Application 1857, she stated: "Doctor called in Mrs. Greenstreet [a private duty nurse] as patient could pay. We did not have confinement." From time to time, Margaret Scott also made notations on the Applications, indicating that she also regularly reviewed them.[80] By 1918, notations by Scott no longer appear on the Applications.

Some entries in the Applications reveal that the voluntary donations given to the Mission by some patients were perhaps, on occasion, less freely given than the Mission's public utterances would have it. Applications 49 and 52, for example, include a note on the bottom, written in Scott's hand, which states "Donation to be given or satisfactory explanation."[81] Application 62 includes an instruction to the nurses, also in Scott's hand, to "Please see that donation is given and entered on this slip."[82] Other comments in the Applications, written in Eliza Beveridge's hand, provide further evidence that some families were pressed to make a donation to the Mission. Application 636 contains the notation that a donation was promised later on, and Application 951 apparently would not

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[80]For example, Case 974 has a notation at the top reading: "examined to date. M.R.S.".

[81]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

[82]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

promise to give a donation.[83] Beveridge carefully noted instances when donations came in some time after the nursing care was provided.[84] She documented at least one case where the supplies provided for the family exceeded the value of the donation they gave, and one instance where a family who were able to hire a private duty nurse for two weeks did not provide a donation when they called the Mission's nurse to the home to attend the delivery of the infant.[85] However, the Mission's Applications confirm that few patients made a donation to the Mission and by 1916, the careful documentation of expected and received donations is no longer seen.

The Mission's work with child bearing and child rearing families created another opportunity for the construction of the normal through the process of women working with women. Post partum visiting was directed not only to the physical care of the mother and infant, but also to changing the child rearing practices of immigrant families. While teaching about breastfeeding, infant care and household hygiene was, in itself, a helpful and often appreciated service, there is little doubt that another agenda also existed. The substitution of Westernized practices for the practices of the immigrant's Eastern European homeland was part of "the normal" constructed by the Mission and its elite supporters:

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[83]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

[84]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief. See, for example, Cases 1950, 1982, 2057, 2091, 2155, and 2205.

[85]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief. Cases 1564 and 3642.

> We pass into the inner room where we find one of our nurses busy bathing and dressing the baby and making the mother comfortable for the day. The poor woman's eyes are sparkling as she gazes at a bright colored quilt sent her by the mission. She is Polish, and cannot speak English, except to say, "Tank you, tank you," but her eyes show her pleasure. The baby, which had only been wrapped in dirty cotton rags before, is now washed and dressed in pretty baby clothes which nurse has brought with her. The mother and children look on admiringly. "English baby," the mother says and smiles.[86]

The Mission's cooperation with other governmental and non-governmental agencies created additional opportunities to construct the normal and participate in the moral regulation of Winnipeg's poor and immigrant populations. From its inception, the Mission operated in close cooperation with a variety of other social institutions and agencies, including the Winnipeg General Hospital, Children's Hospital, Children's Aid, Associated Charities, the Winnipeg School Board, the Salvation Army, the major Protestant Churches, All People's Mission, the City Health Department, the City Relief Department, the Victorian Order of Nurses, the YMCA, the Patriotic Fund, the Town Planning Association, the Red Cross, and the Provincial Social Welfare Department.[87] Cooperation occurred at two levels. At the organizational level, these agencies and organizations collaborated in the planning and implementation of programs aimed at poor and immigrant populations. At the service delivery level, information about individual

[86]Frazer, "A Peep Into the Day's Routine of a District Nurse at the Margaret Scott Nursing Mission," October, 1907. AM, The Mission papers, MG10, Box VI.

[87]This information was drawn from a variety of sources, including the Mission Board of Management Minutes, the Annual Reports, correspondence, newspaper clippings and information documented in the Applications for Nursing Attendance and Relief.. A similar description of the interaction of social agencies for the purpose of moral regulation is described in Fingard, *The Dark Side of Life*.

families was shared between agencies and used as the basis for decisions regarding the family's eligibility for free care. At the heart of the interactions between social service agencies was an explicit consensus that no family would receive more assistance than it deserved. This objective was stated repeatedly in the Mission's documents and public pronouncements. At its1908 annual meeting, Principal D.W. McDermid, president of the Associated Charities, stated that:

> [H]e had heard of one woman who had received sixteen turkeys for Christmas and had been invited out to dinner besides. . . . He asked for harmony and co-operation in charitable work. In giving relief, Mr. Falk [superintendent of Associated Charities] should be asked for information, so that those who refuse assistance may know they have done right. To secure a complete system of investigation, the association has the assistance of the police department, probably of the detectives, of the hospitals and the health departments of the various municipal institutions.[88]

In addition to inter-agency cooperation, direct financial support was another element in the construction of the moralizing web. Not long after its inception in 1904, Mission's Board organized delegations to meet with city, provincial and federal government representatives to secure funding for its work.[89] As a result of these efforts, funding from the City of Winnipeg, the Province of Manitoba and the Immigration Department of the Federal Government was in place by 1905.[90] In addition, the Mission

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[88]*Manitoba Free Press*, "Margaret Scott Nursing Mission Annual Reports Show Wide and Increasing Usefulness of Institution" November 2, 1908.

[89]AM, The Mission papers, MG 10 B9, Box IV, Minutes of Inaugural Meeting, May 12, 1904; Minutes of Public General Meeting, November 12, 1904.

[90]AM, The Mission papers, MG 10 B9, Box V. In the financial statements included in the Annual Report of October, 1906, revenues from the city were $2000.00 per annum, from the Province, $500.00 per annum and from the Immigration Department,

secured the financial support of the Canadian Pacific Railways "in recognition of the benefit of nurses in [the] Weston district."[91]

Cooperation between the Mission and other social agencies enhanced the degree to which moral regulatory strategies penetrated the lives of immigrant families. A joint initiative between the Mission and the Winnipeg School Board, which established the Little Nurses League in 1911, illustrates this point.[92] The program's purpose was to instruct school aged girls about the basics of personal and household hygiene, including food preparation, necessary hours of sleep and "how to guard against flies."[93] Like similar programs offered in other major North American cities, the program's other purpose was to encourage these young girls to teach other members of the family, particularly their mothers, about household hygienic practices. Schools are the most important sites of

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a total revenue of $291.00 which represented a per capita fee to the Mission for each immigrant it treated. This particular method of payment generated considerable paperwork and controversy, since the Immigration Department was reluctant to enter into this agreement in the first place. Once arranged, each family had to be duly authenticated by the Immigration Department, and all efforts to 'encourage' others, including family members, to pay instead of the Department had to be exhausted. See, for example: Box I Correspondence, 1905 and 1906 for letters between the D.W. Bole , M.P. and Louise Minty, Secretary of the Mission regarding the establishment of this funding arrangement, and letters between representatives of the Immigration Department and Minty regarding controversies as to how the payments were verified.

[91]AM, The Mission papers, MG 10 B9, Box V. *Annual Report*, October, 1906. The CPR donated $400.00 per annum. This arrangement appears to have been facilitated by William Whyte, Manager of the CPR's Winnipeg operations. His wife became a member of the Mission's Board of Management in 1905.

[92]AM, The Mission papers, MG 10 B9, Box IV, Minutes of Sept 11 and November 13, 1911; June 10, Sept 9, June 13, and October 26, 1912.

[93]AM, The Mission papers, MG 10 B9, Box IV, Minutes of September 9, 1912.

ideological subjection.[94] Their cooperation with other social agencies such as the Mission to impart knowledge about household hygiene and management imposed behavioural patterns sanctioned by the elite not only on children, but on adult members of the family as well. Although these programs were not, on the face of it, particularly insidious, the manner in which they positioned the school system and the children as normalizing agents within the family ensured that the process of assimilation and Canadianization would be carried out.[95] The Winnipeg School Board was so impressed by the Little Nurses League that in 1913, they undertook complete responsibility for the program and hired Miss Robertson, previously the Mission's employee, to coordinate the program within the school system.[96] Further honours were bestowed upon the Mission when, in 1921, a school in Winnipeg's North End was named for Margaret Scott in recognition of the work that she and the Mission's nurses had carried out with the school-aged children of Winnipeg's immigrant population.[97]

Whether they wielded it or not, the Mission's nurses held considerable power over the families they visited. Their ability to scrutinize the living arrangements and financial circumstances of the Mission's patients made them privy to information that might be of

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[94]Brantlinger, *Crusoe's Footprints.* 92.

[95]The use of the public school system as a normalizing agent has been fully discussed by many historians. See, for example: Copelman, *London's Women Teachers*, particularly Chapters 4 and 5; Davin, *Growing Up Poor*, Chapter 8; Sutherland, "To Create a Strong and Healthy Race", 361-393. Similar strategies were described in *The Foreigner.*

[96]AM, The Mission papers, MG 10 B9, Box IV, Minutes of May 12, 1913.

[97]AM, The Mission papers, MG 10 B9, Box IV, Minutes of March 13, 1921.

interest to other, more punitive social service agencies. For example, destitute recently arrived immigrants could be deported should this situation be discovered in the course of the nurses' visits and shared with the Department of Immigration. Information about neglected children, drunkenness, and marital infidelity could be obtained from and shared with other agencies. For example, Application 6127 documents a situation where a mother, presumed too drunk to care for her children, had been discovered by a police officer and reported to Children's Aid. The subsequent investigation was carried out by Eliza Beveridge, who determined that the mother, although she had been drinking, was not drunk and was able to care for her children. The final disposition of this case is not documented.[98]

Application 6057 is a particularly interesting example of the extent to which information about the immorality of clients' lives were shared amongst the social services agencies. Called to a family home to care for a 26 year old male bricklayer who "seem[ed] not to have much wrong," other information about the circumstances of this family were uncovered and documented. M. Rodger, the investigating nurse wrote: "Woman has 3 husbands." Eliza Beveridge supplemented these comments with the following: "(married to 3) has lived with many men. (Mrs. A. C. in hospital)."[99] Two elements of moral regulation are evident in this case. The first is that some of the information about this family was obtained from another agency. The second is that the

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[98]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

[99]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

detailed documentation about marital infidelity occurs in a situation where the woman was not the individual requiring nursing care, and the man for whom the request for care had been made was not likely to be placed on the Mission's case load. Similar cases signal the Mission's acute interest in the morality of the families they visited. Application 7649 contains documentation about the husband's incarceration for indecent assault, which occurred at least five years prior to the Mission's involvement with the family. Application 10162 records details of a love triangle between a husband, his wife, and the wife's sister. The husband was described as being "on too intimate terms with the wife's sister who refuses to give him up."[100]

In effect, the work of the Mission and its cooperation with other governmental and voluntary social service agencies kept immigrants and the poor under the surveillance of the social elite. If these agencies had been overtly oppressive, open resistance to their presence in the community might well have arisen.[101] However, given that the Mission's work in moral regulation was contained within the provision of much needed and often appreciated nursing care, its efforts to shape the beliefs, values, and behaviours of the populations it served were rarely questioned.

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[100]AM, The Mission papers, MG 10 B9, Boxes VII-X, Applications for Nursing Attendance and Relief.

[101]Adams, ""In Sickness and in Health", footnote 13; Strange and Loo, *Making Good. 140*; Brantlinger, *Crusoe's Footprints*, 97. In describing the instability and complexity of hegemony and moral regulation, these sources states that moral regulation is difficult to achieve. What is key to the success of the process, therefore, is how it is accomplished.

Moral Regulation and the VON

Because their services were provided to those able to pay at least a portion of the nursing fees, the VON reported that their nurses encountered few cases of absolute poverty.[102] The VON's limited contact with charitable cases resulted in very different relationships with its patients. There may well have been a reluctance on the part of the Board to pry into the personal circumstances of respectable citizens who were paying for at least a portion of the cost of their care. Although the VON Board also set up a visiting committee to visit patients in their homes, it was a short-lived experiment. Reports of direct intervention into the personal affairs of patients or their families by members of the Board are also rare.

The less intensive scrutiny of the VON's patients is also confirmed in its written documents. The Board minutes and annual reports give far less attention to the plight of Winnipeg's poor. Instead, these documents focus on the growth of the organization, its financial situation, the development of new programs, and the enhancement of professional standards. With the exception of 1923 and 1924, the VON did not document demographic information about its patients in its annual reports.[103] This information, although it may have been given verbally, was also never documented in the minutes of monthly board meetings. These findings confirm that important differences existed

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[102]VON, Winnipeg Branch, *The Fourteenth Annual Report,* 10.

[103]VON, Winnipeg Branch, *The Twenty-second Annual Report*, 16; *The Twenty-third Annual Report*, 20. This information was, however, routinely collected in the monthly statistical reports which were sent to Ottawa. An example of these reported, for the month of December 1922, is contained in the 1917-18 Minute Book.

between the two visiting nursing agencies and reinforce previous arguments that the governmental and voluntary social service agencies operating within Winnipeg's health care system were primarily concerned about the regulation of poor and non-English speaking citizens.

During the 1920s, however, the VON established one new program that could be readily described as a project of moral regulation. Between 1922 and 1926, it provided a range of maternal-child programs to a group of Ukrainian women. The Ukrainian clinic was located in a church hall at the corner of Arlington St. and Pritchard Ave. in Winnipeg's North End. Space for the clinic was provided by a "Ukrainian priest" and the Board hired Dr. Ellen Douglas to provide medical services. The program was fraught with tension from the onset. On the one hand, the Board and its Medical Advisory Committee believed that the clinic made a significant contribution to the maintenance of social order in the city. The clinic was believed to be a "counteracting influence" on the "communistic influence undermining Ukrainian society."[104] For these reasons, apparently, the VON continued to operate the clinic despite their serious reservations about whether or not it was the proper thing for them to do. Part of the Board's increasing reluctance to operate the clinic was related to fears that it was providing a service more appropriately

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[104]VON, Winnipeg Branch, Minutes of Special Meeting of the Executive and the Medical Advisory Committee, March 27, 1923, 31-3. Subsequent minutes record that three speakers at the Central Council of Social Agencies "had told of Communist meetings being held in the Ukrainian threatre & that a special effort was being made to get hold of the young people." Minutes of November 19, 1924, 150-1. In 1925, a Board member described the principal work of the clinic as "Canadianizing". Minutes of March 18, 1925, 170.

within the mandate of purely charitable organizations.[105] However, the major reason for their ambivalence about the clinic appears to be their reluctance to provide free care to a group of immigrants who were not always willing or able to pay for the services.

Debates about payment for services rendered occurred at two levels. First, the Board could not decide whether or not the women should pay a fee for attending the clinic. When it was first established in 1922, no fees were collected. However, in 1923, at the urging of two Board members, the Board began to insist that the women should pay a fee because it was not the VON's policy to provide free services.[106] This was not entirely true. In several municipalities surrounding Winnipeg, the VON were providing free "teaching visits", child welfare clinics, and mother craft classes.[107] It might be argued that they were not able to provide similar programs free of charge in Winnipeg because they would be duplicating the services provided by publicly funded city health nurses. However, this was not the case. A. J. Douglas, the city's medical health officer, had approved the establishment of the clinic in 1922. Douglas was no doubt aware that this group of patients might not be able to pay for their health care. And, in 1925, the city

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[105]VON, Winnipeg Branch, Minutes of Special Meeting of the Executive and the Medical Advisory Committee, March 27, 1923, 31-3.

[106]VON, Winnipeg Branch, Minutes of March 21, 1923, 27; Minutes of Special Meeting of the Executive and the Medical Advisory Committee, March 27, 1923. The Minutes of March 21, 1923 state that Mrs. Waugh and Mrs. Macleod "both agreed that the patients looked well to do & able to pay a small fee, as they were getting a great deal for nothing." Waugh continued to lobby for the closure of the clinic. In 1924, she suggested that the VON discontinue this service. Minutes of October 15, 1924.

[107]See, for example: VON, Winnipeg Branch, *Twentieth Annual Report,* 14; *Twenty-first Annual Report*, 6, 15; *Twenty-second Annual Report,* 7.

health department refused to send out their child welfare nurses to visit in the homes of patients attending the Ukrainian clinic because "it was not possible at present."[108] Both decisions indicate that the health department was happy to allow the VON to provide services that they did not have the resources to offer.

Insisting that Ukrainian Clinic's patients should pay for the services they were receiving was more likely an outcome of the strength of the VON Board's commitment to the principle of not pauperizing the poor. It evidently believed that the payment of a fee was a tangible reminder to these "foreigners" that they were expected to pay their own way in their adopted city. As a compromise, because the women who attended the clinic truly could not always afford to pay, the Board encouraged them to sell embroidery and give the proceeds to the VON.[109] This money was used to defray the costs of Dr. Ellen Douglas's salary.[110]

Conflict about payment also occurred between the VON and the priest whose church was used to house the clinic. Ironically, the Board did not feel obligated to pay rent for the building and rebuffed overtures on the part of the priest to at least pay rent during the winter to defray the cost of heating the building. The solution instituted by the Board was to have the women who attended the clinic provide the coal to heat the building. Clinics were cancelled for two weeks in the winter of 1922 while this problem

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[108]VON, Winnipeg Branch, Minutes of September 20, 1922; Minutes of November 18, 1925.

[109]VON Winnipeg Branch, Minutes of Special Meeting of the Executive and the Medical Advisory Committee, March 27, 1923.

[110]VON, Winnipeg Branch, Minutes of April 18, 1923.

was sorted out.[111] A year later, the Board decided that the building needed to be cleaned and "calcimined," and requested the priest to arrange to have this done. However, when the priest asked if they would share the money received from the clinic's patients to defray the costs associated with cleaning the building, they refused to do so.[112]

Throughout the entire period of the Ukrainian Clinic's existence, the VON Board vacillated in its support of the clinic and its opinion of the patients. The most remarkable example of the Board members' ambivalence is documented in the minutes of 1925. In April, Mrs. Weed reported to the Board that she had "gone to it [the clinic] prejudiced, but came away feeling that on account of these maternity cases & from the health standpoint it was worthwhile. She felt that the women were unable to pay." [113] Ten days later, she telephoned the Board President stating that she had "revised her opinion" and felt that the Board must make a decision about whether or not to offer services to a group of women who refused to go to the [Winnipeg General] Hospital for obstetrical care.[114] In the summer of 1926, the clinic was closed. The services offered at that location were to be continued by "their own Mutual Benefit Society . . . and by the out patient department"

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[111]VON, Winnipeg Branch, Minutes of November 15, 1922.

[112]VON, Winnipeg Branch, Minutes of June 20, 1923.

[113]VON, Winnipeg Branch, Minutes of April 15, 1925.

[114]VON, Winnipeg Branch, Minutes of April 25, 1925. Questions about whether or not the VON should operate the clinic are also documented in the minutes of March 27, 1923, April 18, 1923, September 24, 1924, October 15, 1924, December 17, 1924, April 15, 1925, November 18, 1925, April 16, 1926.

of St. Joseph's Hospital.[115] Although moral regulation was an integral part of the whole process of defining illness and providing medical and nursing care, with the exception of the Ukrainian Clinic, it was a less visible aspect of the VON's interactions with its patients and a less pressing issue for its Board.

Conclusion

The analysis of the Scott Mission's work provides powerful evidence that, in addition to the provision of health care, it also aspired to fashion immigrants into good Canadian citizens and to shape their beliefs, values and customs to conform with those of the city's political and cultural elite. The social, cultural, ethnic, and religious differences observed between the Mission and its patients support the argument that it operated in the domain of moral regulation. Simply put, if there were no differences at all between these two groups, the Mission would not have existed. If the differences were purely related to medical need, it could be argued that the Mission was simply the vehicle to enable one group, which had the financial resources, to provide health care to the other group which did not. However, medical need was the least striking difference between the Mission's supporters and its patients. Both rich and poor women gave birth to children. Both groups experienced acute illnesses, chronic diseases and outbreaks of communicable diseases. With appropriate financial and human resources, Winnipeg's poor and immigrant populations could have provided for their own health care needs. The fact that they were not simply enabled to do so and were, instead, forced to depend on institutions and systems created by Winnipeg's social elite, supports the argument that more than health

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[115]VON, Winnipeg Branch, Minutes of September 15, 1926.

care was delivered to the homes of "the foreigners."

At its heart, moral regulation seeks to suppress overt differences between the elite and "the other" while, at the same time, maintaining existing power relations. This, too, can be seen in the Mission's work, which sought to bring cleanliness, order, and "higher things" into the homes and families of Winnipeg's immigrant districts. However, advocacy for their rights as citizens and workers was never undertaken. Compassion, pity, and charity were provided. Equal status was not.

The Mission was particularly effective as a moralizing agent because it provided much-needed health care to those who had no other recourse. Elite women and nurses, clothed in the guise of "angels of mercy," could enter the homes of "the foreigners" and interact directly with immigrant women. Along with the physical care, the medications and the material support, the moral and behavioural standards of the elite could be tactfully and unobtrusively conveyed to immigrant mothers and daughters. Few would be willing to turn such assistance away. By emphasizing their sympathy and concern for their "less fortunate sisters," elite and middle class women obscured the very real social, political, and cultural differences between the two groups and encouraged conformity to the gendered practices of the dominant culture.

Resistance to the work of agencies such as the Mission, when it did begin to emerge in the 1920s, came in the form of health care institutions modelled on those established by Winnipeg's social and political elite. The founding of St. Joseph's Hospital (Ukrainian/Russian) in 1923, Mount Carmel Clinic (Jewish) in 1926, and Concordia Hospital (Mennonite) in 1928 is evidence that Winnipeg's immigrant populations

preferred to avoid the cultural imperialism that accompanied health care services provided by Winnipeg's Anglo-Canadian social elite.[116] The founding of separate health and social agencies was an important step in the immigrant community's assertion of its ability and desire to provide for its own needs on its own terms.

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[116]Carr and Beamish, *Manitoba Medicine*, 82.; Mitchell, *Medicine in Manitoba*; Dueck, *Concordia Hospital*.

Chapter 7

The Integration of Female-Led Voluntary Public Health Programs into Civic Health Departments: The Case of Winnipeg's Child Hygiene Program 1910-1918

Introduction

Industrialization, immigration and the migration of significant numbers of individuals and families from agricultural areas to the city created explosive growth in major Western cities. Britain was the first nation to experience the human death toll associated with unregulated and unprecedented urban growth.[1] By the mid nineteenth century, similar scenes were unfolding in New York City, Chicago and Boston.[2] In short order, Montreal and Toronto were also forced to confront the health, social, and political consequences of urban overcrowding, inadequate sanitary infrastructures and poverty.[3] As malnutrition and disease stalked the filthy streets and squalid tenements of the modern city, death rates soared and life expectancy decreased.[4]

Of all who suffered misery, illness and death in the slums of the industrial city,

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[1]Bynum, *Science and the Practice of Medicine,* 62-64; Eyler, *Victorian Social Medicine*; Stallybrass & White, *The Politics and Poetics of Transgression,* 125-148; Wohl, *Endangered Lives*.

[2]Rosen, *A History of Public Health,* 209-224, 317; Wald, *The House on Henry Street,* 1-12; Wolf, *Don't Kill Your Baby,* 46-47.

[3]Bliss, *Plague*; Copp, *The Anatomy of Poverty*; Piva, *The Condition of the Working Class in Toronto*.

[4]William Farr, a British physician and statistician, established the basic methodologies of epidemiology, statistics and demography during his tenure in the General Register Office 1839-1880. His Fifth Annual Report reported that, while the average life expectancy in Britain was 41.16 years, in Liverpool, the nation's least healthy industrial city, it was only 25.7 years. Eyler, *Victorian Social Medicine,* 135.

none paid a higher price than newborn children and infants under the age of one year.[5] The "Herodian districts" of John Simon's London were faithfully replicated in all major Western industrial cities. Infant mortality rates rose steadily and remained high even when mortality rates for other groups began to fall in response to improved sanitary measures and containment of communicable disease outbreaks.[6]

Ultimately, the failure of regulatory strategies and sanitary infrastructure development to reduce infant mortality rates forced male public health officials and politicians to seek other interventions to complement those already included in the mandates of civic health departments. Because of their interactions with female-led voluntary health care agencies, health officials were aware that the hygienic and child care practices of many families, particularly immigrant and working class families, were significantly different from those promulgated by middle class adherents of maternal feminism and scientific motherhood. By the early twentieth century, public health officials and civic politicians had thus developed a professional interest in the impact that maternal household hygienic practices had on the health of infants and children. Because civic regulatory strategies had limited utility in a campaign to transform the domestic care of infants and children, health education became the intervention of choice. No precedent

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[5]In his Fifth Annual Report, William Farr estimated that only half of the children born in Liverpool lived to their fifth birthday. This is an child death rate of 500/1000 births. Eyler, *Victorian Social Medicine,* 135. Most children died in infancy. Terry Copp, in his analysis of public health in Montreal, estimates that the infant mortality rate in Montreal in 1900 was approximately 300/1000 births. Copp, "Public Health in Montreal." In contrast, in 1997, Canada's infant mortality rate was 5.5/1000 births.

[6]Bynum, *Science and the Practice of Medicine.*

for this type of intervention existed within publicly funded civic health departments. These male dominated organizations had not yet integrated face-to-face interactions with women and children into their programs, nor did their staffs include the female employees who could, according to the sexual division of labour of the time, undertake this type of work. However, voluntary female-led visiting nursing associations possessed several decades of experience in bringing the "gospel of health" to the "ignorant masses" living in the slums and tenements of the industrial city. In fact, in a society divided by gendered assumptions about the appropriate social roles for men and women, elite female reformers perceived the work of educating mothers about the proper care of their children as rightfully theirs. The allocation of funds from male civic authorities to support their work further solidified their mandate to take a leadership role in the reduction of infant mortality rates through health education and direct contact with their "less fortunate sisters."

Over time, the gender-based division of labour between male public health officials and female social reformers was reshaped and transformed. Several factors underlay this process. The magnitude of the infant mortality problem overwhelmed the financial and human resources of charitable organizations. In many cases, it also exceeded their limited geographic reach. The restricted range of interventions available to both elite women and nurses, who lacked full access to real professional, political, and legal power, also limited the effectiveness of their efforts. The idea of "scientific motherhood" advanced the professional aspirations of the new medical speciality of pediatrics and made both visiting nurses and mothers more dependent on physicians for

advice about child rearing practices and infant feeding. This development de-stabilized earlier beliefs that experienced, knowledgeable women were the best resource for new mothers seeking guidance about their maternal role.

The child hygiene programs pioneered by elite women also became increasingly politicized. Babies became, in the minds of ambitious politicians and businessmen, fundamental elements in the project of nation building. Every infant life saved was an investment in the nation's future.[7] Initially pioneered and funded by elite women or operated by elite women with the financial assistance of civic health departments, efforts to reduce infant mortality rates ultimately entered a second stage when these programs were taken over by civic health departments. As a result of both the increased medicalization of childhood and the explicit link created between nation building and healthy babies, the gendered basis of women's participation in public health programs was both challenged and reshaped by professional and bureaucratic men. In the process, female led efforts to reduce infant mortality rates were taken over by professional medicine and civic health departments.

This chapter traces Winnipeg's experience in combatting the high infant mortality rates it experienced between 1900 and 1918. It focuses initially on the leadership role that elite women played in the development of health education programs to reduce infant and child mortality across Canada and the United States. Then, focussing on Winnipeg, it analyses the factors that led to the Margaret Scott Nursing Mission Board's decision to pioneer Winnipeg's first child hygiene program and the role that the city's medical health

[7]Comacchio, *Nations are Made of Babies*, 3-4, 16-42.

officer, A. J. Douglas, played in encouraging the Board to add this program to its existing mandate of providing charitable bedside nursing care to the poor.[8] It will assess the impact of the child hygiene program on the Mission's financial status and outline the factors that led to Douglas's decision to integrate the program within the city's health department. Finally, it will examine the methods and motives of health care professionals and bureaucrats, and analyze the impact of their interventions on Winnipeg's poorest citizens.

In the Shadow of Death: Child Health Programs in the Early Twentieth Century

In the hot dry summer of 1912, a tragedy of unprecedented proportions was unfolding in Winnipeg. An unrelenting heat wave, which saw daytime temperatures hover as high as 98.2°F., brought dust, flies, and sleepless nights to the homes of its long-suffering citizens.[9] Although these discomforts could be endured in the expectation that autumn would bring cooling precipitation and killing frosts, one outcome of the summer of 1912 could not be ignored. The babies were dying.

In his 1912 *Annual Report*, Douglas painted a grim picture of the events of that fateful summer. Infant deaths for the year totalled one thousand and six. Three hundred and forty-four infants died between June and August. One hundred and sixty-two died in

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[8]Similar analysis of the VON's experience with child hygiene programs in Winnipeg's adjacent municipalities will not be provided because these programs operated outside of the boundaries of Winnipeg proper. The extant records of VON Winnipeg do not provide sufficient detail about their child hygiene programs to support a satisfactory analysis.

[9]CWA, Department of Health, *Annual Report* (1912), "Meteorological Statistics for the Year 1912," 17.

the month of August alone. The infant mortality rate for the year rose to the unprecedented height of 199.5/1000 births.[10] But these bald facts did not reveal the full magnitude of the problem. While the overall ratio of infant deaths to live-births was one in five, in the homes of Winnipeg's immigrant population, the death toll exceeded two in five live-born infants.[11] For Winnipeg's newest and poorest citizens, the routine miseries of overcrowding, squalor, subsistence wages, and bigotry were tragically compounded by the deaths of their children.

Winnipeg's situation was not unique. It was simply the latest in a long list of British, American, and Canadian cities that, burdened by the strains of immigration, poverty and unplanned growth, experienced a rise in child and infant mortality rates in the late nineteenth and early twentieth century. In earlier times, the tragic deaths of these innocent children might have been noted with sorrow and forgotten. Babies have always been vulnerable and a higher death rate in the first year of life was (and still is) a normal component of relative risk for death throughout the life span. However, what had changed, in addition to the magnitude of the problem, was the public perception of the role that children played in industrial society. Beginning in the late nineteenth century, the state began to make unprecedented incursions into the previously private domain of reproduction and child rearing. This change was inspired both by the transformation of family economics and the reshaping of childhood itself. Children were gradually removed

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[10]CWA, Department of Health, *Annual Report* (1914), 172; *Annual Report* (1917), 133; *Annual Report* (1918), 123.

[11]CWA, Department of Health, *Annual Report* (1913), 172.

from economic production and placed into the public school system. In this more public setting, the myriad of preventable health problems and communicable diseases from which they suffered were rendered visible to the publicly funded school system and to the state.[12]

An equally powerful factor in the recalculation of the social value of children was the fear of race suicide.[13] Elite and middle class birth rates had been dropping since the early 1870s, engendering fear that they would soon be overwhelmed as a social and political force by the waves of immigrants arriving from southern and eastern Europe. In this context, every child, even the native- born child of an immigrant, became a precious element in the patriotic process of nation-building.[14]

Rising infant death rates became unacceptable in a society that placed such significance on the production and rearing of healthy, intelligent future citizens. The unease engendered by the high infant mortality rate was further intensified by the realization that the emerging discipline of public health had not yet fulfilled its early promise to improve the health of the nation's future citizens. Sanitary improvements and regulation of the milk supply had not saved babies' lives. Instead, almost perversely, infant death rates in most large urban centres had continued to increase even after these

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[12]Harris, "Education, Reform, Citizenship and the Origins of the School Medical Service," 95-97; Peikoff and Brickey, "Creating Precious Children," 29-54.

[13]McLaren and McLaren, *The Bedroom and the State,* 11; Stern and Markel, "Introduction," 5.

[14]Peikoff and Brickey, "Creating Precious Children" 55-61.

public health measures had been enacted.[15]

Male politicians and medical health officers may well have been pressed beyond the limits of their mandates and imaginations by the continued rise in infant mortality rates, but other members of society believed that they had both the solution to the problem and the moral or scientific authority to act. Elite and middle class women, eager to ease the suffering of women and children, focussed on health education both for themselves and for their less fortunate "sisters."[16] Physicians in private practice, particularly those carving out specialist practices in the emerging discipline of pediatrics, also embraced the notion of the well educated mother and created new approaches to preserving the lives of infants in children. In so doing, these groups carved out new terrain for both themselves and public health departments, and paved the way for a change in emphasis from bacteriology and regulation to health education in the practice of public health.

Health education has been identified as the second great paradigm shift in the public health movement in Western industrialized countries. From a formal public health program perspective, Elizabeth Fee places this development between the First and Second World Wars.[17] However, careful examination of the evidence indicates that many women were actively seeking and creating health education programs to reduce infant mortality and to promote the health of children much earlier. Julia Grant asserts that "good

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[15]Meckel, *Save the Babies*, 95.

[16]Ladd-Taylor, *Mother-Work.*

[17]Fee, "Public Health and the State", 244-246.

mothering" became a public concern in the mid-to-late nineteenth century as the raising of healthy, well-adjusted children was linked with nation building and the uplifting of society in general. Although many anxious mothers, believing that child rearing "was a discipline that had to be learned," turned to "experts" for advice, the authorities they both sought and trusted were more likely to be other mothers than physicians.[18] Allopathic physicians, preoccupied with consolidating their monopoly over the medical profession, were ill-prepared to assist women in their quest for helpful advice about their maternal responsibilities. Although some physicians in the United States began to develop exclusive practices in the care of children as early as the 1860s, pediatrics did not emerge as a specialist practice until near the end of that century.[19] More importantly, women believed that they were uniquely qualified to both generate and disseminate information about childhood and effective child rearing practices. Well-educated middle-class women, both in the United States and Great Britain, authored books on the subject.[20] Voluntary maternal associations dedicated to education of mothers sprang up across the United States. These self-help groups were as popular among working class mothers as they were among members of the middle class.[21] As maternal associations organized nationally, they became politically active. Operating under the rubric of "municipal

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[18]Grant, *Raising Baby by the Book*, 21-23.

[19]Klaus, *Every Child a Lion*, 83; Stern and Markel, "Introduction," 6; Viner, "Abraham Jacobi and the Emergence of Scientific Pediatrics," 23.

[20]Grant, *Raising Baby by the Book*, 24-38; Gurjeva, "Child Health," 107-111.

[21]Grant, *Raising Baby by the Book*, 24-38.

housekeeping," maternal feminists actively sought to put traditionally domestic concerns such as the well-being of women and children on the public agenda.[22]

The development of pediatrics as a medical speciality also had a significant impact on the development of programs to reduce infant and childhood mortality. Medical dispensaries, essentially free-standing outpatient departments of major urban hospitals, provided free medical care to indigent patients throughout much of the nineteenth century. Because of the overwhelming number of sick infants and children brought for medical attention, dispensaries were an essential element in the clinical education of many young physicians who emerged as pediatric specialists late in the century.[23] American historian Howard Markel estimates that eighty-five percent of the founding members of the American Pediatric Association had obtained significant clinical experience working in hospital dispensaries and orphanages.[24] Abraham Jacobi, generally recognized as the world's first professor of pediatrics, acquired his scientific and practical skills in pediatrics during his practice amongst the poverty-stricken German immigrants of New York City's Lower East Side.[25]

By the late nineteenth century, the appalling infant mortality rates documented in the slums of large urban centres came to the attention of both physicians and female

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[22]Flanagan, Maureen, "Gender and Urban Political Reform,"'; Howe, "Gender and the Welfare State"; Lewis, "Women's Agency".

[23]Markel, "For the Welfare of Children," 54-55; Meckel, *Save the Babies*, 129.

[24]Markel, "For the Welfare of Children," 55.

[25]Viner, "Abraham Jacobi," 25-26.

social reformers. Both groups believed that working class and immigrant mothers were "ignorant" and barely capable of performing the essential tasks of providing a safe and healthy environment for the nation's future children. Because removing these "unfortunate" children from their parents was no longer a viable option, other interventions were developed.[26] Female social reformers soon found that the most effective vehicle to bring the methods of modern motherhood to the homes of the urban poor was the visiting nurse.[27] Begun as modest experiments by wealthy female philanthropists who hired trained nurses to provide health education and physical care to the sick poor, by 1900 one hundred and fifteen local visiting nursing associations operated in the United States.[28] Great Britain and Canada boasted national visiting nursing organizations.[29] These agencies employed nurses who, in addition to providing bedside nursing care in the home, also pioneered programs to safeguard the health of infants and children. From their beginnings, visiting nursing associations provided postpartum instruction in the home to women who had delivered infants under their care. Because visiting nurses were well acquainted with the consequences of bottle feeding

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[26]For a discussion of the movement away from the use of orphanages and foster homes to care for at-risk children, see: Peikoff & Brickey, "Creating Precious Children."

[27]Klaus, *Every Child a Lion*, 74-76; Markel, "For the Welfare of Children," 56-57; Meckel, *Save the Babies*, 129.

[28]Klaus, *Every Child a Lion*, 70-71.

[29]Buhler-Wilkerson, *No Place Like Home*; Fitzpatrick, *The National Organization for Public Health Nursing*; Penney, *A Century of Caring*;

infants, a major focus of their health teaching was the promotion of breast feeding.[30] Given the inadequate safety of the milk supply in most urban centres, and the inadequate provisions for the cold storage of milk in many households, bottle feeding of infants was associated with a very high death rate. In 1912, it was estimated that a bottle fed infant over the age of two weeks was six times more likely to die than a breast fed infant.[31] Although the interventions of visiting nurses were intended to provide mothers with the benefits of the most modern information about the care of infants and children, the effectiveness of postpartum instruction in the home was limited. Nurses visited the homes of new infants for only a short period of time. Typically, newborns were seen daily for ten days after birth, and then on a more irregular basis until the nurse was satisfied that both the mother and infant were thriving.[32] This was barely sufficient time to communicate with mothers whose first language was not English, or to change traditional infant care practices that had been handed down from one mother to another for generations. As well, these visits had no impact on mothers who stopped breast feeding later in the postpartum period.

Dispensary physicians and pediatricians were also well aware of the dangers associated with bottle feeding and of the failure of dairy by-laws to reduce infant mortality rates. Dairy by-laws clearly did not influence how milk was handled once inside the home. In the 1890s, Arthur Newsholme, Medical Officer of Health in Brighton, Great

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[30]Wolf, *Don't Kill Your Baby*, 108.

[31]Davis, "The Prevention of Infant Mortality by Breast Feeding," 70.

[32]Wolf, *Don't Kill Your Baby*, 107.

Britain concluded, based on extensive epidemiological and bacteriological evidence, that the domestic contamination of milk had far more impact on infant mortality than did its contamination during production or delivery to the home.[33] This finding, widely supported in the medical community, created pressure for an intervention that surmounted the inability of impoverished families to provide adequate cold storage facilities in their own homes. As well, pediatricians' increased preoccupation with the precise chemical composition of the infant's diet had led to the development of complex formulas which were difficult even for the most experienced practitioners or well educated mothers to prepare.[34] All of these factors led to the development of milk depots to supplement the existing public health campaign to regulate dairy producers and civic milk supplies. Milk depots provided modified and pasteurized cows milk formulas on a daily basis to newborn infants. As well as ensuring that the infant was consuming the safest milk possible, this procedure reduced the risk that the milk would spoil, once in the home, because of the lack of ice or refrigeration. In addition, because the milk was provided free of charge to those who could not afford to pay for it, milk depots ensured that poor and destitute families were not excluded from the benefits of this intervention.

Milk depots in the United States, Britain, and Canada were established through locally determined coalitions that could include wealthy male philanthropists, elite female social reformers, religious groups, physicians, visiting nursing associations, and/or civic health departments. In the United States, Abraham Jacobi had suggested the

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[33]Meckle, *Save the Babies*, 98.

[34]Klaus, *Every Child a Lion*, 84-87; Wolf, *Don't Kill Your Baby*, 74-86.

establishment of milk stations where the poor might buy safe milk at affordable prices as early as 1881.[35] The expense of this program was a severe constraint on its implementation, and it was not until 1893 that Nathan Strauss, a wealthy New York businessman, opened a milk station in the Lower East Side.[36] Although the first civic milk stations were established in Rochester, NY in 1897 and in New York City in 1910, in most American cities, coalitions of concerned citizen groups perhaps with the financial support of civic authorities, provided the funding and personnel to operate milk depots.[37] Similarly, both publicly and privately funded milk depots were established in British and Canadian cities.[38] In Montréal, twenty *gouttes de lait* were established between 1910 and 1913 by the *Fédération National Saint-Jean-Baptiste*, an organization of francophone women dedicated to charitable work to alleviate the suffering of working class women and children.[39] The VON, Canada's national visiting nursing association, established a milk depot to serve the city's English speaking population in 1911.[40] In Toronto, a variety of women's groups, settlement houses, and church missions established milk depots to

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[35]Meckel, *Save the Babies*, 78.

[36]Klaus, *Every Child a Lion*, 69; Markel, "For the Welfare of Children," 56; Meckel, *Save the Babies*, 78; More, *Restoring the Balance*, 83-84. Dr. Henry Koplik, a New York pediatrician, had actually opened a milk station in 1889, but it distributed milk to sick infants only.

[37]Klaus, *Every Child A Lion*, 71-73; Meckel, *Save the Babies*, 79.

[38]Marland and Gijswijt-Hofstra, "Introduction," 11.

[39]Baillargeon, "Entre la 'Revanche' et la "Veillée' des Berceaux," 113-137.

[40]Gibbon, *The Victorian Order of Nurses for Canada*, 47.

serve that city's poorest citizens in the early twentieth century.[41]

Milk depots were quickly reshaped into well baby clinics where mothers could obtain both inexpensive or free infant formulas, and specific guidance regarding the care of their children.[42] The clinics were generally staffed by volunteer physicians eager to gain experience in the primary care and nutrition of infants. Nurses were sometimes employed to assist with the operation of the clinic, the preparation of formulas, and record keeping. However, the combination of on-site health education and free formula did not deliver the returns anticipated by the proponents of milk depots. [43] Much more intensive work with at-risk families was required. Based on the model already pioneered by elite female reformers, home visits by public health nurses or visiting nurses were instituted to investigate the family's living conditions, to provide more specific instruction to the mother, and to monitor the family's progress.[44] In New York City, under an innovative program spearheaded by Dr. S. Josephine Baker, head of the health department's newly formed Department of Child Hygiene, school nurses were redeployed during the summer months to assist with the milk depots' home visiting programs as early as 1908.[45] However, in many other cities where school boards and public health departments did not employ nurses, visiting nursing associations were approached to

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[41]MacDougall, *Activists & Advocates*, 161-162; Royce, *Eunice Dyke*.

[42]Markel, "For the Welfare of Children," 56-57.

[43]Meckel, *Save the Babies*, 124-129.

[44]Buhler-Wilkerson, *False Dawn*, 104.

[45]Meckel, *Save the Babies*, 134-36.

provide health education in the homes of newborn infants and milk depot patients. Professional and lay organizations such as the American Association for the Study and Prevention of Infant Mortality, the American Pediatric Association, the American Public Health Association and the American Nursing Association actively promoted maternal health education and child hygiene initiatives. Conference delegates attending their annual meetings actively debated the thorny issues associated with whether or not these programs should be publicly or privately funded, and which professional or lay group had the necessary qualifications to occupy leadership positions in their delivery.[46]

Medical inspection of school aged children was another initiative directed primarily towards encouraging working class and immigrant families to adopt more middle class child rearing practices. Because female-led voluntary groups such as visiting nursing associations lacked the legal authority to enter schools, school medical inspection programs were initiated by school boards or civic health departments. Physicians, either voluntary or salaried, conducted the physical examinations.[47] However, it was quickly realized that home visits to the families of sick or disabled school-aged children might be a useful augmentation of the on-site medical services already in place. In New York City,

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[46]See, for example: MacNutt, "The Board of Health Nurse, 3; Locke, "The Problem of our Infant Population," 18. MacNutt's paper, which was read at the 1912 Annual Meeting of the American Public Health Association, sparked an extensive discussion on the role of the child welfare (child hygiene) nurse and the appropriate organizations which might offer nursing services to families of newborn infants. This discussion is reproduced on pages 350-353 of the same issue of the *American Journal of Public Health*.

[47]See, for example: Sutherland, "To Create a Strong and Healthy Race."

the medical inspection of school aged children was established in 1893.[48] However, an unfortunate consequence of the systematic surveillance of the children's state of health was a high rate of absenteeism and an equally high rate of children failing to fully recover from illnesses identified by medical health inspectors. Lillian Wald, founder of the Henry Street Settlement House, persuaded school authorities to allow her to assign visiting nurses to four schools to demonstrate their utility in decreasing the number of children sent home from school by providing follow up home visits and health education to supplement the existing medical inspection program. The pilot program, conducted in 1902, was such a success that in 1903, the city's Board of Health hired twelve nurses to continue the program. Similar school nursing programs, administered by either civic authorities or by visiting nursing associations working in cooperation with them, sprang up across the United States.[49]

In Great Britain, legislation was passed in 1907 that enabled local authorities to institute medical inspection programs in the state-supported schools.[50] In that same year, the first Canadian medical inspection program in public schools was implemented by the Montréal School Board. Its development was watched with considerable interest by Canadian nurses, who were well aware that their American colleagues were bridging the divide between school-based physicians and the domestic circumstances of school aged children by providing follow up care and health education in the home. School health

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[48]Markel, "For the Welfare of Children," 57-58.

[49]Buhler-Wilkerson, *False Dawn*, 98-100.

[50]Harris, "Educational Reform," 85.

programs, the editor of *The Canadian Nurse* observed, were an appropriate field for "intelligent, well educated and progressive nurses . . . because . . . no system of medical inspection in schools has yet been satisfactory unless the aid of the nursing profession was enlisted."[51] This was high praise indeed, given that the editor at that time was a physician.

Once in the schools, nurses identified other opportunities to extend the scope of their practices to augment already established milk depot and health education programs directed at reducing infant mortality. In New York City, a League of Little Mothers Program was initiated in the summer of 1909 to teach the principles of infant feeding and household hygiene to school aged girls who were left in charge of infant siblings while their mothers worked.[52] In addition, school aged children were taught the basic principles of personal hygiene and nutrition in the hope that this knowledge would not only influence their behaviour, but also that of their parents. By 1911, there were two hundred and thirty-nine Little Mothers Leagues in New York City alone.[53]

By the second decade of the twentieth century, the fragile coalition between female social reformers, physicians, and civic health departments that had created the child saving movement had begun to erode. Because of the linkages between healthy children and nationhood, many social reformers believed that child saving programs

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[51]MacMurchy, "New Field for Nurses," 486.

[52]Grant, *Raising Baby by the Book*, 82; Meckel, *Save the Babies*, 144; Stothart, "The Big Sister at School," 485.

[53]Klaus, *Every Child a Lion*, 77-78.

should be operated by the state rather than by voluntary agencies.[54] "For many of these unfortunate infants" stated J. H. Mason Fox Jr., President of the American Association for Study and Prevention of Infant Mortality, "the state or the city should stand in 'loco parentis.'"[55] In the shorter term, however, limited financial resources also constrained the capacity of voluntary organizations to operate labour and capital intensive programs such as milk depots and child hygiene programs.[56] By the early twentieth century, many of these programs had been taken over by civic health departments. This was the case in Toronto, for example, where child saving programs offered by a variety of charitable organizations were consolidated under the auspices of the Health Department's Child Hygiene Department in 1914.[57]

Schisms also developed between female reformers and physicians. Proponents of maternal feminism clung to their belief that maternal education and social reform would, in the long run, enable most mothers to provide appropriate care to their infants and children without undue dependence on the intervention of health care professionals or the state.[58] Although female social reformers believed that advances in medical science could be harnessed to the agenda of the child saving movement, their more egalitarian vision of motherhood was increasingly at odds with the idea of scientific motherhood embraced by

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[54]Buhler-Wilkerson, *False Dawn*, 105.

[55]Knox, "The Importance of Birth Registration," 44.

[56]Buhler-Wilkerson, *False Dawn*, 105.

[57]MacDougall, *Activists & Advocates*, 161-162

[58]Klaus, *Every Child a Lion*, 87.

organized medicine, the new speciality of pediatrics, and the professionalized infant health movement.[59] Successful medical practices depended upon mothers knowledgeable enough to provide safe infant care, but not so knowledgeable that the services of a physician were unnecessary. In part, mothers' increasing dependence on physicians was accomplished through increasingly complex instructions regarding the infant's physical and emotional needs, and proper infant nutrition.[60]

As the female-led child saving movement gained momentum in the United States, child saving programs previously offered under the auspices of voluntary agencies such as milk depots, settlement houses, and visiting nursing associations were also offered by the Federal Government through the Children's Bureau, which was established in 1912 after nearly a decade of intense lobbying by influential American women's groups.[61] Passage of the Sheppard-Towner Act in 1921 provided federal funding to support the establishment of child health clinics in both urban and rural areas of participating states. However, maternal feminists such as the predominantly female staff of the Children's Bureau were no longer viewed by physicians as equal partners in the campaign to save

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[59]For a fuller discussion of scientific motherhood, and the way in which this approach was viewed by maternal feminists on the one hand, and health care professionals on the other, see: Arnup, "Educating Mothers," 196-203; Brosco, "Weight Charts and Well Child Care," 110; Comacchio, *Nations are Built of Babies*, 66-67; Grant, *Raising Baby by the Book*, 4-6; Gurjeva, "Child Health," 107-122; Ladd-Taylor, *Mother-Work*, 4, 33, 45, 83; Stern, "Better Baby Contests at the Indiana State Fair"; Wolf, *Don't Kill Your Baby*, 86-87

[60]Arnup, "Educating Mothers,"; Comacchio, *Nations Are Built of Babies*; Wolf, *Don't Kill Your Baby*, 86-101.

[61]Ladd-Taylor, *Mother-Work*, 74-98.

children's lives. Increasingly confident members of the medical profession believed that the programs operated by female reformers were "soft" and "unscientific,"and that charitable infant welfare programs supported by public funds threatened their livelihoods.[62] The repeal of the Act in 1929 resulted in the closure of these clinics and effectively relegated women to the margins of the child saving movement.[63]

In Britain and Canada, female social reformers never gained the political power so briefly enjoyed by their sisters in the United States. Large government bureaucracies dedicated to the promotion of maternal and child health were set up soon after the First World War. Although women had lobbied intensively for these programs, they were often excluded from participation in their implementation.[64] As several historians of the welfare state have observed, female social reformers linked their agendas to those of male professionals and politicians at their peril. The usual result of these improbable and unstable coalitions was that women lost control of the programs that they had pioneered and proven effective.[65]

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[62]Markel, "For the Welfare of Children," 57; Stern and Markel, "Introduction," 8.

[63]Ladd-Taylor, *Mother-Work*, 167-196; Stern and Markel, "Introduction," 10.

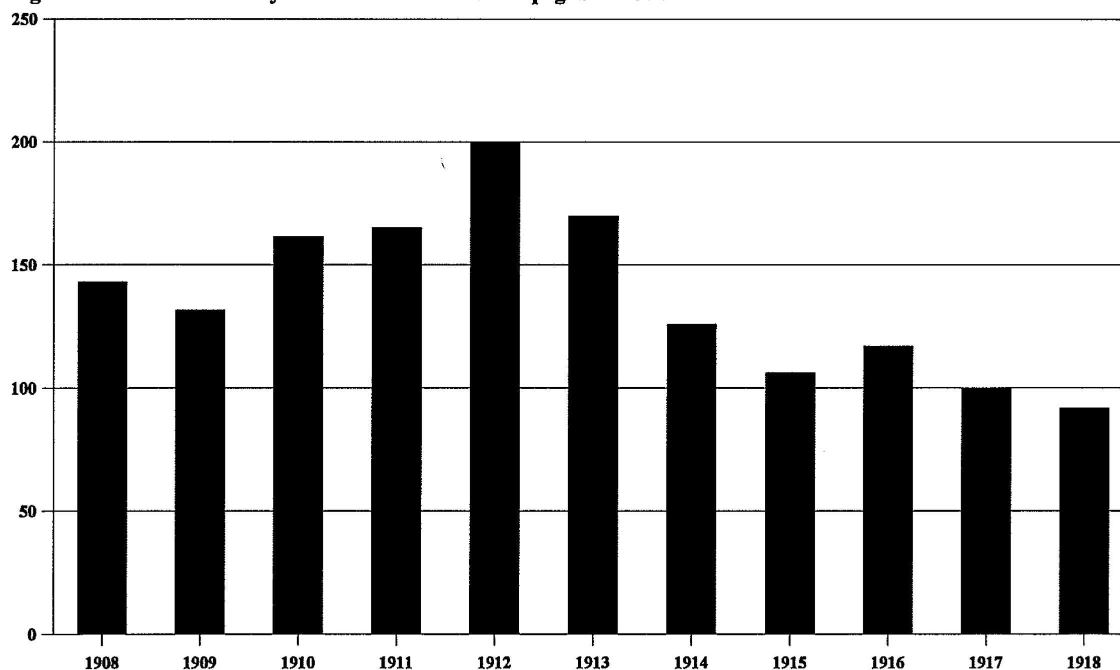
[64]Arnup, "Educating Mothers," 190-210; Koven and Michel, "Womanly Duties"; Pedersen, "The Failure of Feminism,"; Pierson, Lévesque and Arnup, "Introduction," xiii-xxiv; Sklar, "A Call for Comparisons".

[65]Koven and Michel, "Womanly Duties"; Koven and Michel, "Gender and the Origins of the Welfare State"; Sears, "Before the Welfare State".

Saving Babies in Winnipeg: The Scott Mission and the City Health Department

In Winnipeg, efforts to save the lives of the city's children followed a very similar pattern. The health department's focus on sanitary improvements and regulatory strategies had not had any impact on infant mortality rates. In fact, by 1910, it had become clear that the infant mortality rate was increasing (Figure 7-1). It was at this point that the health department reached out to the city's women for help. Both the Ladies' Service League of the Winnipeg Free Dispensary, a free-standing facility operated by the Winnipeg General Hospital, and the Margaret Scott Nursing Mission responded to the call to arms and entered the fight to save the city's children.

Figure 7-1: Infant Mortality Rates/1000 Births: Winnipeg 1908-1918



Source: CWA, Health Department, *Annual Reports*, 1917, 1918.

In 1910, Winnipeg's first milk depot was organized by the Ladies' Service League of the Winnipeg Free Dispensary. From its inception, the Depot focussed its efforts on providing free infant formula for families who could not afford to purchase it out of their own budget or who lacked the facilities for safe milk storage in the home. Families who could contribute to the cost of the infant's feedings were encouraged to do so, but inability to pay was not a barrier to the Milk Depot's services. Its operations met with the enthusiastic approval of health department officials who commented regularly on its fine work in departmental *Annual Reports*. City Council provided a $750.00 per annum allocation to support the operations of the Depot.[66] Although there is no evidence that Douglas was directly involved in the decision to open the Milk Depot at the Free Dispensary, given his clinical appointment at the Winnipeg General Hospital and the Manitoba Medical School, his enthusiasm for the program, and his involvement in encouraging other charitable organizations to provide health care services for Winnipeg's poor and immigrant citizens, it is safe to assume that he had a hand in encouraging the women to establish this program.

Douglas also turned to a charitable, female-led organization to provide assistance in the education of the mothers of newborn children. On June 10, 1910, a formal Child Hygiene Program was founded under the auspices of the Scott Mission. The circumstances which led to this development are sufficiently interesting to quote at length from the Board Minutes:

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[66]CWA, Health Committee Communications 1913-1914. File 1001/2. Letter from Mrs. H.S. MacMillan re: Babies' Milk Depot.

> Mrs. Scott introduced Miss Rathbone to the meeting & she spoke of the subject of providing for the proper feeding of infants during the summer months. She said she had found such an utter lack of care on the part of the mothers for their children due in the majority of cases to ignorance. Dr. Douglas had issued, she said, an excellent pamphlet with minute directions but many were not able to understand & could not follow directions without practical demonstration. She requested that a special nurse be provided to take up this work in connection with the M.S.N.M., she herself being occupied in looking after the tubercular patients. A letter was read from Dr. Douglas expressing his approval of the plan & his hope that it would be carried out. Mrs. Haggart moved, Mrs. Bain seconded that a nurse should be engaged for 3 months to work in this connection. Carried. Mrs. Scott said already she had been promised the money necessary to pay a nurse for three months and that she recommended engaging Miss Bradshaw. This was left with Mrs. Scott to do whatever she thought best.[67]

What is so remarkable about this development is the carefully orchestrated manner in which this proposal was placed before the apparently unsuspecting Board members. Rathbone was a visiting nurse employed by the Anti-Tuberculosis League of Winnipeg.[68] Although not a health department employee, she was in regular contact with Douglas because of the need to coordinate her activities with those of the health department.[69] There is little doubt that Douglas was directly involved in the strategy to use the Mission as the vehicle to deliver a child hygiene program in Winnipeg and that he, Rathbone, and Margaret Scott had conferred prior to Rathbone's appearance at the Board meeting. All the elements required to establish the program had already been put into place when the Board convened. Funding for the program had already been secured,

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[67]AM, The Mission papers, MG 10 B9 Box IV Board of Management Minutes, June 10, 1910.

[68]CWA, Health Department, *Annual Report* (1911), 11.

[69]CWA, Health Department, *Annual Report* (1909), 6.

and a nurse with the necessary qualifications had already been identified.[70] This meant that the Board had little to do except agree or disagree with the proposal and, given the respect they held for Scott, there was little danger that they would disagree.

The Board's decision to take on child hygiene work was not without its challenges however, because it created a second mandate for the organization that was not entirely compatible with its primary mandate of providing charitable visiting nursing service to indigent individuals and families. The Child Hygiene program sought to prevent infant mortality and morbidity by teaching the basic principles of breast feeding, the introduction of solids into the baby's diet, and general household hygiene to all mothers of newborn infants. The fit between the two programs was not always comfortable, primarily because the Board was most interested in charitable work and not all families visited under the auspices of the Child Hygiene program fell into this category. However, the Mission's Board and its nursing staff made the necessary adjustments to carry out these additional responsibilities.[71]

In 1911, the Mission expanded its efforts to reduce infant and childhood mortality rates when it conducted a Little Nurses' League program as a demonstration project for the Winnipeg School Board. Scott had apparently read about the New York City experiment and concluded that a similar program would be beneficial in Winnipeg.[72] In

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[70]AM, The Mission papers, MG 10 B9, Box IV, Board of Management Minutes, June 9, 1910.

[71]"The Florence Nightingale of Winnipeg," 141-142.

[72]"The Florence Nightingale of Winnipeg," 142.

the fall of 1911, Scott, members of the Mission's Board, representatives of the health department, and representatives of other agencies "interested in preventing Infant Mortality" waited as a deputation upon the Winnipeg School Board to persuade them to offer a similar program in Winnipeg schools.[73] The results of the meeting are not specifically documented in the Mission's minutes. However, given the fact that it was the Mission that carried out this project over the 1911-1912 school year in selected schools in Winnipeg's North End, it would appear that the School Board wanted some evidence of the program's efficacy prior to taking on responsibility for it. By the fall of 1912, the School Board, evidently satisfied with the results of the demonstration project, took over responsibility for the program and for the nurse who had been hired by the Mission to implement it. In recognition of the apparent success of the Mission's demonstration project, the number of schools in which the program was offered was also expanded.[74]

Thus, by 1911, Winnipeg's female social reformers, in cooperation with the city health department and the Winnipeg School Board, had put into place "a whole grand project of bettering our people and nation" through the implementation of a comprehensive approach to the reduction of infant mortality.[75] The health department carried out sanitary and bacteriological programs. Charitable voluntary agencies organized the provision of infant feedings, and the education and supervision of mothers

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[73]AM, The Mission papers, MG 10 B9, Box IV, Board of Management Minutes September 11, 1911; November 13, 1911: CWA, Department of Health Annual Report for 1911, 6-7.

[74]AM, The Mission papers, MG 10 B9, Annual Report, June 10, 1912, 7.

[75]"Child Welfare Work in [the] City of Winnipeg,", 812.

of newborn infants. The school system undertook the education of young girls in the essentials of infant and household hygiene. Douglas's 1911 *Annual Report* commented favourably on all of these developments, but already a note of caution was creeping into his description of these coordinated efforts to reduce infant mortality. The infant mortality rate, he stated, was still too high, and more nurses were needed during the summer months "as certain of our foreign-born population need to be followed up very persistently and vigorously."[76]

Despite the best efforts of all concerned, 1912 brought crushing disappointment and a renewed sense of urgency to the Scott Mission and the health department. The city's persistently high infant mortality rate sparked a lengthy discussion at the Mission's October 14th Board meeting. "The Board," the Minutes record, " were shocked to learn from Mrs. Scott that the death rate among infants in Winnipeg is said to be greater than in any other city on this Continent."[77] Douglas, too, was frustrated with the evident lack of progress in saving the lives of Winnipeg's babies. The death rate, he stated in that year's *Annual Report*, was "altogether too high, and steps must be taken immediately and energetically to lower it."[78] However, this would not be a simple task. In addition to the record infant mortality rate experienced that year, there was also mounting evidence that

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[76]CWA, Health Department, *Annual Report* (1911) 6.

[77]AM, The Mission Papers, MG 10 B9, Box IV, Board of Management Minutes, October 14, 1912.

[78]CWA, Department of Health, *Annual Report* (1912), 3-4. This report was tabled on March 27, 1913 at the City Council's Health Committee meeting. CWA, Health Committee Minutes 1909-1920, 152.

the voluntary organizations responsible for interacting directly with at-risk mothers and infants could not continue their work. The combination of increasing demands upon the services of these agencies and inadequate funding ultimately resulted in the termination of both the Mission's Child Hygiene Program and the Women's Service League Milk Depot in 1914.

The strain on the Mission's resources had become apparent within a year. In September 1910, Scott reported to the Board that the three month experiment in child hygiene work had revealed such a great need that it was advisable to employ a nurse permanently to carry it out.[79] By October 1911, it had become necessary to employ a second nurse to cope with the demands on the program.[80] The increase in staff created uncomfortably crowded conditions at the Mission's Home. Board of Management and Advisory Board discussions regarding the advisability of enlarging the current structure at 99 George St. or building a new Home ensued.[81] However, the precarious financial position of the Mission made both options untenable.

In early 1912, the Board, on the advice of Douglas, approached city council

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[79]AM, The Mission papers, MG 10 B9 Box IV, Board of Management Minutes September 12, 1910.

[80]AM, The Mission papers, MG 10 B9 Box IV, Board of Management Minutes, October 9, 1911.

[81]AM, The Mission papers, MG 10 B9 Box IV, Board of Management Minutes. *Manitoba Free Press,* undated article. Pasted in the minute book of the MSNM after the annual meeting of October 1911.

seeking additional funding to employ another Child Hygiene nurse.[82] They were turned down, a decision that further destabilized their financial situation. Douglas was clearly disappointed by this development. In a letter to the Mission Board, he "expressed regret at the refusal of this request, as he considered the decreased death rate among infants due entirely to the nurses of the Child Hygiene Department instructing the mothers as to the care and feeding of their babies."[83]

Despite the gravity of their situation, and perhaps inspired by the example of Scott, who sincerely believed that Providence would provide the faithful with the means to carry out their work, the members decided to carry on:

> The treasurer then read her financial statement, showing the deplorable balance of $110 in the bank and unpaid bills to the extent of two hundred odd dollars. The Board were however cheered by the fact that the city grant of $1200 was not yet in and the refund from the School Board, therefore it was moved by Mrs. Drewry, seconded by Mrs. Riley & carried that the bills be paid.[84]

However, in less than a year, the financial and organizational strains introduced by the Child Hygiene Program became insurmountable. In September of 1914, the Board turned the Child Hygiene program within the city limits over to the health department, retaining

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[82]AM, The Mission papers, MG 10 B9 Box IV, Board of Management Minutes, January 8, 1912.

[83]AM, The Mission papers, MG 10 B9, Box IV, Board of Management Minutes, October 14, 1912.

[84]AM, The Mission papers, MG 10 B9 Box IV, Board of Management Minutes, October 14, 1912.

one nurse to continue to visit newborns outside of the city limits.[85]

The Milk Depot of the Ladies' Service League met a similar fate. In February 1914, Mrs. H. S. MacMillan submitted a lengthy letter to the Health Committee advising that they could not continue to operate the Depot. Despite the city's financial support and their best efforts at fund raising, the League was essentially bankrupt. As had been the case with the Mission, a combination of factors led to this situation. As MacMillan succinctly stated:

> With, however, the great increase in the demand (necessitating a doubling of the staff) and the constant raising of the rent, it has in the last two years been impossible to make ends meet and the entire building fund is wiped out and the league is unable to pay the whole of its accounts.[86]

As had been the case in many other North American cities, the zeal that inspired female social reformers to pioneer programs in direct aid of mothers and babies could not be matched by their financial resources. Their only solution was to transfer these programs to civic authorities secure in the knowledge that the need had been effectively demonstrated, and that the methods to meet those needs had been tested and found effective.

The City of Winnipeg Child Hygiene Program: 1913-1918

The way had been paved for a Child Hygiene Division within the health department prior to the collapse of the Mission's Child Hygiene Program and the Ladies'

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[85]The Mission's suburban Child Welfare program was transferred to the Provincial Department of Health in 1922. AM, The Mission papers, MG 10 B9, Box IV, Board Minutes, September 14 & December 14, 1914; Board Minutes of Feb 12, 1922.

[86]CWA, Heath Committee Communications 1913-1914. File 1001/2. Letter from Mrs. H.S. MacMillan re: Babies' Milk Depot.

Service League Milk Depot. Douglas had apparently already concluded that the efforts of voluntary associations alone would not be sufficient to reduce Winnipeg's infant mortality rate. His next strategy was introduced in the health department's 1912 *Annual Report* when, while praising the efforts of these voluntary agencies, he made the case for the delivery of visiting nursing services under the auspices of the health department:

> These private enterprises should be encouraged in every way; but more than this is needed. A Child Welfare Division added to this Department would, we feel sure, soon make its presence felt in a lowering of this death rate. We would like to see this started at once.[87]

In February 1913, Douglas tabled an estimate of the cost of establishing a Child Welfare Division within the health department.[88] Within five years, this new initiative became one of the department's largest and most expensive programs. From a staff of two trained nurses in 1913, the Child Welfare Division grew to nine nurses and four other employees in 1918. Costs rose accordingly. In 1913, the budget for the entire operations of the new division was $2500.00.[89] In 1918, the Division's budget was $25,797.77, consuming twenty-three percent of the Health Department's total allocation.[90]

The first two civic Child Welfare nurses commenced their work on May 8, 1913. Their duties included contacting every household where a live birth had been registered, providing teaching and information about infant feeding, encouraging mothers to breast

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[87]CWA, Health Department, *Annual Report* (1912), 4.

[88]CWA, Health Committee Minutes, 1909-1920, 150.

[89]CWA, Health Committee Communications, 1911-1913, Files 812, 819, 1036/7.

[90]CWA, Department of Health, *Annual Report* (1918), 6.

feed, assessing and following up on sick infants and mothers, making appropriate referrals to hospitals or city physicians, and providing essential items such as infant clothing, bottles, and rubber nipples when necessary. In addition, they referred families to other agencies such as the Associated Charities and the Milk Depot, reported insanitary conditions to the Sanitary Division of the Department and made home inspections prior to the return of convalescent children from hospital.[91] Throughout 1913 and early 1914, Nurses Smith and Wonnacott submitted monthly reports directly to the medical health officer. Douglas, in turn, tabled them at regular meetings of the city Health Committee.

On April 1, 1914, the health department took over the staff and equipment of the Ladies' Service League Milk Depot and relocated its operations to a rented house at 31 Martha Street. The building also served as a residence for the department's child hygiene nurses. Two additional nurses were also hired by at this time. These developments substantially changed the organization of the Child Hygiene Program and the reporting mechanisms followed by the nurses. A Child Hygiene Division was formally organized in 1914, and P. B. Tustin, Chief of the Food and Dairy Division, was put in charge of its operations. From this point on, all communications regarding the Division's work were channelled through Tustin to Douglas and thence to the Health Committee.

The demands on the Child Hygiene program increased dramatically between 1914 and 1918. The staff increased from four to nine nurses within four years and, judging by the tone of the Division's annual reports, more nurses could have been used. Tustin, on more than one occasion, stated that the workload for each nurse was too high and that

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[91]CWA, Health Department, *Annual Report* (1913), 168.

better success could be achieved if the families in need of assistance could be visited more frequently.[92]

The demands on the Milk Depot also increased dramatically. In June of 1915, Tustin reported to Douglas that the space at 31 Martha St. was inadequate and that new quarters would have to be found.[93] A subcommittee of the Health Committee was struck to investigate this situation. On July 15, 1915, the sub-committee reported that they had reached an agreement with the Board of Children's Hospital which gave the city a twenty-two year lease and permission to erect a Milk Depot on the hospital property fronting Aberdeen Ave. [94] Thus, in the space of a year, the department had modified its original plan of operating the Milk Depot on a temporary basis to make what was in essence a generation-long commitment to provide this service. The new Milk Depot, "the first of its type in Canada," opened in February, 1916.[95]

Douglas's new approach to the reduction of infant mortality in the City of Winnipeg bore fruit within the year. In the 1914 *Annual Report*, he was able to report a reduction in infant mortality from 169.8/1000 births in 1913 to 125.9/1000 births in 1914. Douglas was convinced that this achievement was primarily due to the fact that the

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[92]See, for example: CWA, Health Department, *Annual Report* (1915) 105; *Annual Report* (1916), 118.

[93]CWA Health Committee Communications, Box 716, May 19, 1915. P.B. Tustin. "Report of the Bureau of Child Hygiene for April, 1915."

[94]CWA, Health Committee Communications, Box 716, File 1276/1280/1, 1310/1/2.

[95]"Child Welfare Work in the City of Winnipeg," 811; CWA, Health Department, *Annual Report* (1916), 115.

department had at last consolidated an effective approach to the problem under its jurisdiction. "It is only during the past two years" he stated, " that this problem has been at all adequately dealt with by this department."[96] Except for a slight increase in 1916, the infant mortality rate continued to decline steadily. In 1917, it stood at 100 deaths/1000 births, putting Winnipeg, for the first time, "in the A1 Class of cities on the North American continent for its infant mortality rate."[97] In 1918, the infant mortality rate again decreased to an all time low of 91.9 deaths/1000 births (Figure 7-1). Sanitary, bacterial, and educational strategies, in combination with the centralization of all services within the health department, had enabled Douglas and the staff of the Child Hygiene Division to achieve what must have seemed, in 1912, to be an almost unattainable goal.

Saving Babies as a Project of Moral Regulation: A Sober Second Look

There can be little doubt about two aspects of the Mission's and Douglas's efforts to reduce Winnipeg's high infant mortality rate. The first is that the programs they implemented were consistent with those emerging in other major British, American and Canadian cities during the same era. The second is that these programs produced the desired results (Table 7-1). From the perspective of traditional medical history, it would be sufficient to end the analysis of the campaign to reduce infant mortality here. From other perspectives, however, the bare narrative of Douglas's Child Hygiene Program is only the beginning.

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[96]CWA, Health Department, *Annual Report* (1914), 6.

[97]CWA, Health Department, *Annual Report* (1917), 101.

Table 7-1: Comparison of Infant Mortality Rates For Selected Canadian, American and British Cities: 1908-1918

	1908	1909	1910	1911	1912	1913	1914	1915	1916	1917	1918
Winnipeg	143.1	131.6	161.4	165.1	199.5	169.8	125.9	106.3	117.0	100.1	91.0
Hamilton	156.2	134.2	143.7	122.0	145.7	130.8	120.1	115.2	111.9	102.2	99.6
Montreal				300*	230						
Toronto			131								
Hartford							104	157	100		
New York								94			
Boston				126	117	107					
London, GB			103								
Liverpool			139								
Manchester			132								
Edinburgh			103								
Belfast			143								
Dublin			142								

Sources: CWA, City of Winnipeg Department of Health Annual Report for 1918; Copp,"Public Health in Montreal"; Gallivan,"Child Hygiene," 327-331; Locke, "The Problem of our Infant Population," 523-526; McDougall, *Activists and Advocates*; Montreal Child Welfare Exhibition, *Program*; Roberts, "Twenty-three Years of Public Health,"554; Rosen, *A History of Public Health*; "Some English Ideas on Infant Mortality,"134.
*estimated

What predominates in the story of Winnipeg's campaign to reduce its infant mortality rate are the voices of those in authority. The narratives of "the others," those for whom and upon whom the interventions were directed, are not recorded in the minutes, correspondence, proceedings, or journals of the professional and political elite. There is, in fact, a perceptible distance between those who implemented programs to combat infant mortality and those who were the recipients of these services. The names of some involved in the campaign to conserve Winnipeg's babies are honoured to this day as humanitarians and innovators. Those served by the program are both nameless and

faceless. These dynamics suggest that Winnipeg's Child Hygiene program was a project of moral regulation. Indeed, many elements of the campaign to save infant lives resonate with other places and circumstances in which people organized to change the behaviours and beliefs of others.[98] Projects of moral regulation have several discrete elements including a moralized subject, a moralized object, a body of knowledge, a discourse that normalizes this knowledge, a prescribed set of practices to be adopted, and a potential harm to be avoided or overcome.[99] All can be found in Winnipeg's campaign to reduce infant mortality in the years between 1900 and 1918.

The moralized subject in Winnipeg's child hygiene program was the immigrant parent. The fact that the city's infant mortality rates rose to unprecedented heights at the same time as immigrants from Eastern Europe began arriving in unprecedented numbers made immigrant parents, particularly mothers, an obvious target for the interventions of charitable organizations and public health officials. Elite, professional and middle-class Winnipegers all feared that the influx of "strangers" would transform the social dynamics of the city beyond all recognition.[100] This anxiety was similar to that experienced in other major American and Canadian cities. The sense of urgency about the impact of immigration on the nation was heightened by the realization that native-born Americans and Canadians were not only in danger of being outnumbered, but also outproduced by foreigners whose birthrate was much higher than theirs. As one American expert in the

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[98]Hunt, *Governing Morals,* ix.

[99]Hunt, *Governing Morals,* 7.

[100]Artibise, "Divided City."

field of public health stated:

> A glance at our recent vital statistics will convince one that an alarming condition exists in our country today; namely, that our "good old American stock", as we have chosen to call it, is being rapidly supplanted by foreign stock because of the relative lack of productiveness.[101]

Despite these concerns, or more likely, because of them, the major focus of charitable and government health care agencies in all major Western industrialized cities was the implementation of public health and social welfare programs for immigrant families with infants and children. Nativism and xenophobia shaped the services offered by these agencies. For example, both the implementation and the evaluation of efforts to reduce infant mortality in many North American cities were built around the assumption that ethnicity was somehow involved in the etiology of infant mortality. This was certainly the case in Winnipeg.

Soon after the Child Hygiene program was organized in Winnipeg, a statistical analysis of its impact was initiated. In 1913, the ethnic origin of the mother was used a dependent variable for the first time.[102] (Figure 7-2) This analysis revealed that the highest infant mortality rates were experienced amongst central and southern European families. While this was undoubtedly true, what elite and professional reformers, both in Winnipeg

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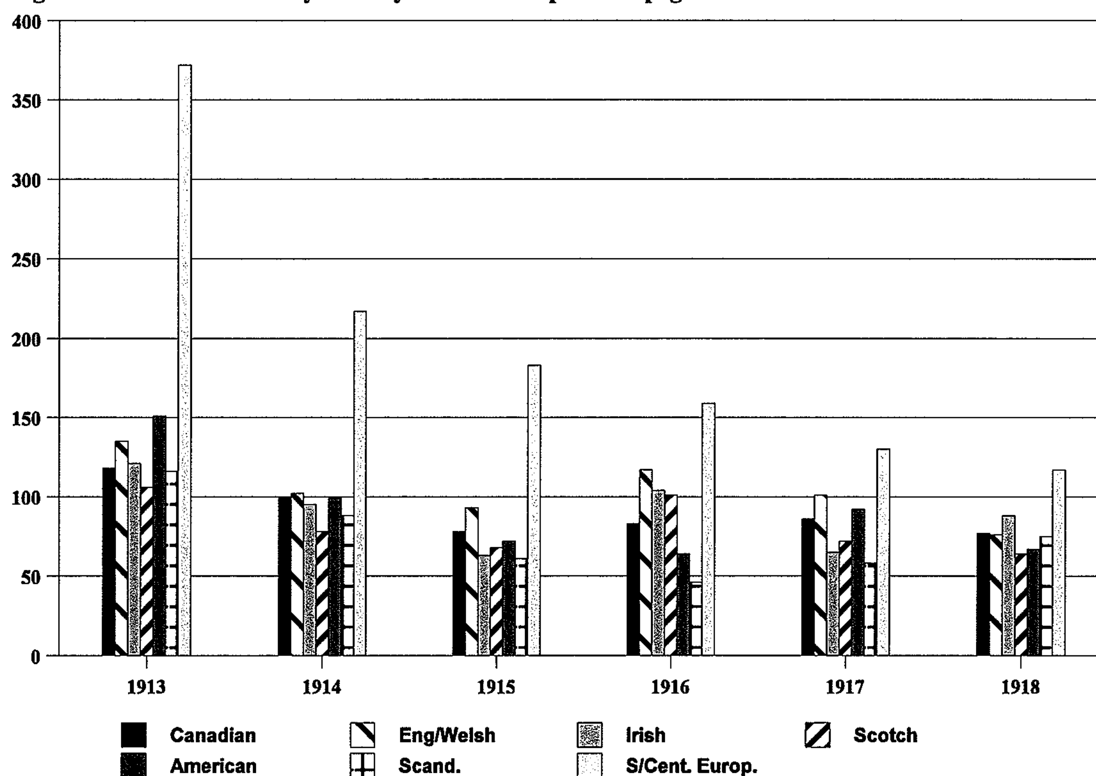
[101]Locke, "The Problem of our Infant Population," 523.

[102]This approach to the collection of statistics regarding infant mortality was consistent with that in use in other major Canadian, American and British cities. The use of ethnicity as a dependent variable reveals the extent to which public health reformers were pre-occupied with the problem of immigration and ethnicity. In his analysis of the impact of William Farr on 19th century British public health, Eyler comments that "Some historians (M.J. Cullen, Philip Abrams) have demonstrated that statisticians tended to collect, analyze and report their data in a manner which fulfilled their own political and social agendas." Eyler, *Victorian Social Medicine,* 22.

and elsewhere, either overlooked or chose to downplay was that these babies were not dying because their mothers were "ignorant" immigrants. They were dying because their mothers were poor.[103]

Figure 7-2: Infant Mortality Rate by Ethnic Group: Winnipeg 1913-1918



Source: CWA, Health Department, *Annual Report*, 1917, 1918.

Both elite female social reformers and male public health officials believed that the responsibility for the high infant mortality rates rested with immigrants who lacked the necessary knowledge to provide proper care for their children. However, there were

[103]For an extended discussion of the impact of poverty on infant mortality specifically and life expectancy generally, see: Piva, *The Condition of the Working Class in Toronto*; Copp, "Public Health in Montreal."

subtle differences in the degree to which these two groups moralized the subjects of their health education campaigns. In the case of the Scott Mission, the minutes reveal, with the exception of a few judgmental statements about maternal "ignorance," a profound sense of sympathy for the plight of their patients.[104] As well, the Board's description of the problem as "defective knowledge" rather than "maternal incompetence" conveys a sense that they believed that the mothers visited by the Mission's nurses were capable of attaining the same standard of mothering skills that they themselves possessed.[105]

The documents of the city health department convey a far more judgmental attitude. The extent to which the link between maternal "ignorance" and infant mortality predominated in the thinking of male public health officials is revealed in P. B. Tustin's analysis of a curious anomaly in Winnipeg's infant morality statistics for 1916. Although still higher than those experienced by all other Winnipeg families, infant mortality rates continued to decline in immigrant families. In British and Canadian families, however, a slight increase in infant mortality rates had been observed (Figure 7-3). This, stated Tustin, must be due to the fact that "the stress of economic conditions has fallen harder upon British families than upon families of foreign born parents" during wartime.[106] Given that the 1916 death rate amongst eastern and southern European infants was 159/1000 births, while that amongst Anglo-Celtic and Canadian infants averaged 117

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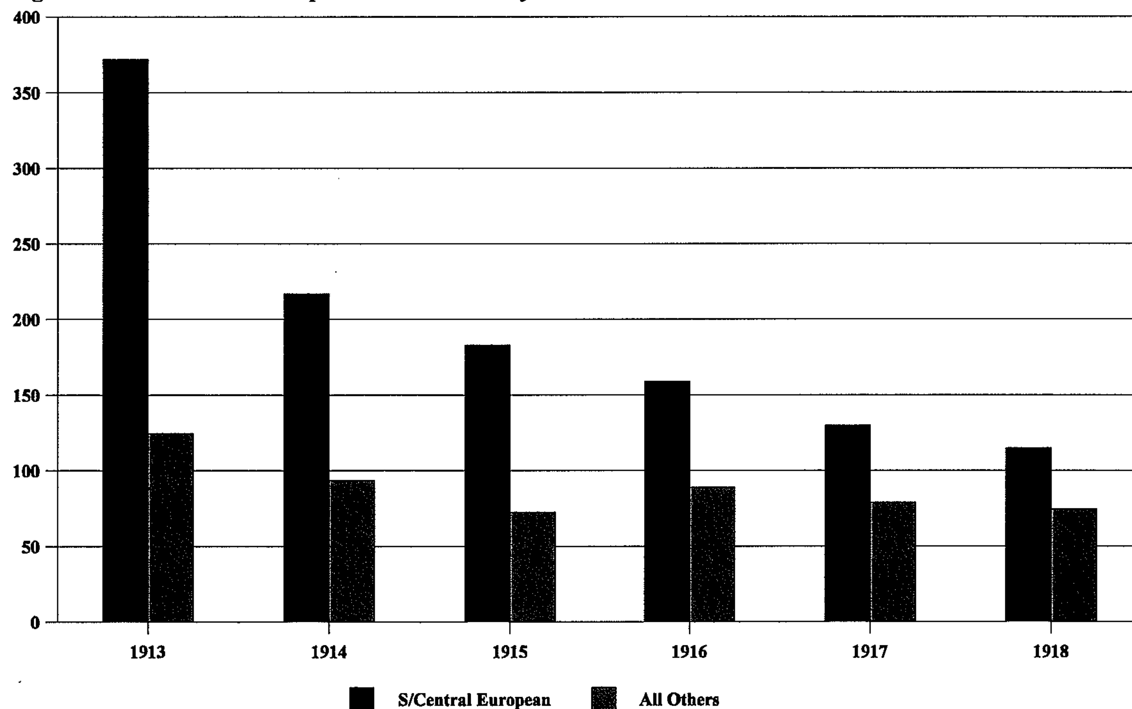
[104]See, for example: AM, The Mission papers, MG 10 B9, Box IV, Board of Management Minutes, March 13, 1911 and April 8, 1912.

[105]AM, The Mission papers, MG 10 B9, Box IV, Board of Management Minutes, January 9, 1911.

[106]CWA, Health Department, *Annual Report* (1916), 150.

deaths/1000 births, one is hard pressed to understand how this could be the case. Evidently, only Anglo-Celts and Canadians had recourse to the argument that poverty had been the major factor placing their infants at higher risk of death.

Figure 7-3: South/Cent. European Infant Mortality Rate vs. All Others



Source: CWA, Health Department, *Annual Reports*, 1917, 1918.

Interpreting infant mortality as a moral issue related to the "ignorance and neglect" of immigrant mothers rather than as an economic issue related to high unemployment, poor wages, and inadequate living conditions kept the blame firmly fixed on the victims of these conditions rather than on those with the power and means to change them. Even if poverty was acknowledged as having a role in infant mortality, public health officials could easily evade the issue by pointing out either that education

was the more important remedy for the problem, or that the alleviation of poverty was not the purview of health departments. Both Douglas and P. B. Tustin stated these opinions in their annual reports. "We recognize that economic conditions are responsible for a large portion of the infantile mortality" stated Douglas in 1911, "but we feel that no matter how bad the economic conditions, a very large number of children's lives could be saved if the mothers only knew that in the care of infants what not to do is often more important than what to do."[107] To his credit, Douglas was at least willing to recognize that poverty played a role in the etiology of infant mortality. Some leaders in the field of public health actively denied that this was the case. "I cannot believe" stated Julius Levy in a 1919 article published in the *American Journal of Public Health*, "that low income bears any very constant or causal relation to infant mortality."[108]

The moralized object of efforts to reduce the infant mortality rate was the newborn child. At the heart of the child saving movement was the belief that children were the country's future. Immigrant parents might lack the intelligence and moral fibre necessary for the creation of the utopian state envisioned by the middle class, but their children could, with proper care and education, take their place as the citizens of tomorrow. Immigrants were perceived as perilously close to dependence upon the state for survival. This outcome was to be avoided, at all costs, amongst their children. The state's responsibility was to ensure that they were strong, healthy, and able to make their

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[107]CWA, Health Department, *Annual Report* (1911), 7. P.B. Tustin stated in a subsequent Annual Report that poverty was a matter for the Associated Charities, not the Health Department. CWA, Health Department, *Annual Report* (1914), 130.

[108]Levy, "Reduction of Infant Mortality," 676.

own place in the nation of tomorrow.

Constructing infant mortality as a moral problem for which parental education was the primary solution created an opportunity for the emerging professions of medicine, engineering, and nursing to use their knowledge and expertise to combat insanitary conditions and maternal "incompetence," the twin threats to the production of healthy future citizens. Using the tools of sanitation and bacteriology, and deploying specialized knowledge about infant care, these new civil servants did succeed in reducing infant mortality rates. As well, these initiatives enhanced the ability of women and older children to care for newborn infants in a manner that would meet the approval of the social and political elite. However, these strategies also kept attention focussed on the deficiencies of individuals and families, particularly mothers, rather than on those of the social system as a whole. Health education, as well as imparting much needed information to new mothers, also convinced them that the best way to ensure the health of their infant was to scrutinize their own performance of the skills associated with modern child care. The proper role of both the child hygiene nurse and the medical health officer was, in fact, to provide the specialized knowledge and supervision that would facilitate regulation of the self. As J. Scott MacNutt so eloquently stated in his 1912 address to the Municipal Officers Section of the American Public Health Association:

> If all tuberculosis patients and their families could be taught and persuaded to act as their own sanitary police, and if all mothers could be instructed to apply a few fundamental rules in the care of their infants, the remaining cares of the sanitary authorities in these matters would be secondary.[109]

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[109]MacNutt, "The Board of Health Nurse": 345.

Health professionals clearly believed that their unique bodies of knowledge could contribute substantially to the greater social project of saving the lives of Canada's babies and "thus ensure a healthy, intelligent and moral generation of young Canadians equipped for the tremendous nation building tasks that await them."[110] In so doing, physicians and nurses created new roles for themselves as civil servants and bureaucrats within the nascent welfare state. For physicians, the public health program's success in eradicating communicable disease and reducing infant mortality cemented their exclusive claim to the role of health officer in local and provincial departments of health.

In the late nineteenth and early twentieth century, there was no consensus on the question of which profession was best suited for the role of municipal health officer, although it was clear that the successful candidate would be a male. As late as January of 1911, an article in the *American Journal of Public Health* stated that the professional qualifications of the health officer mattered less than whether or not *he* [italics mine] was modest, competent, qualified and judicious.[111] Despite the confident tones in which William Sedgwick proffered this opinion to the *Journal's* audience, it was clearly, by this time, a minority opinion. The influence of non-medically trained health officers was rapidly waning despite the efforts of sanitary engineers and others to assert their claims to leadership roles in health departments.[112] Organized medicine had succeeded in grasping these positions for its members. "In approaching the problem of the selection of the health

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[110]Matthews, "Child Welfare,"16.

[111]Sedgwick, "On the Proper Correlation of Physicians," 31.

[112]Fee, "Public Health and the State" 243.

officer" stated George W. Goler, M.D. "it must be conceded that *he* [italics mine] must be drawn from the ranks of the medical profession."[113] But training in conventional medicine was not sufficient for this new practitioner. To knowledge in the fundamentals of pathophysiology and the treatment of disease that formed the foundation of private medical practice were added knowledge in sanitation, hygiene, health education, research, and public administration. The emerging welfare state demanded all of these skills, and more, from its professional medical officers of health.

Another outcome of the ascendency of the male medical profession both within the civic departments of health and in private practice was their eventual success in taking over previously established voluntary programs dedicated to the prevention of infant mortality. Pediatricians in private practice used the ideals of scientific motherhood to consolidate their role as experts in the raising of health children. Medical health officers took over voluntary child saving programs and centralized them within local health departments. This precedent was established by the New York City Department of Health, which began the process of centralizing all Child Hygiene programs in 1908. Winnipeg's female philanthropists had looked to Great Britain for their inspiration when establishing their early visiting nursing services. Douglas, on the other hand, looked to his American colleagues for the best examples of the professionally led and publicly funded public health programs.

Nurses were less successful in carving out leadership positions for themselves within civic health departments or in claiming the full professional status ascribed to their

[113]Goler, "How to Get and Keep Competent Health Officers," 601.

medically trained counterparts. Karen Buhler-Wilkerson asserts that public health nursing lost much of its autonomy when the services these nurses provided were moved from voluntary organizations, which were frequently managed by elite women, to public health departments headed by male medical officers of health.[114] It was, she asserts, the events culminating in the centralization of public health programs within departments of health that cost nursing its best opportunity to attain full professional status.

In Winnipeg's case, these claims are difficult to either prove or disprove. There is little evidence that the Scott Mission's nurses participated fully in decisions about the organization's mandate generally, or in the Mission's decision to implement a child hygiene program. While Eliza Beveridge, the Mission's Superintendent of Nursing, influenced the day to day details of the nurses' practice, the Board's focus on the provision of bedside nursing care for charity patients effectively limited the scope of nursing practice within the organization. Between 1904 and 1912, there was remarkably little variation in the Mission's description of its nurses' practice in the community, even though it had piloted and demonstrated the effectiveness of two innovative public health programs. Autonomy and innovation, both cornerstones of professional practice, did not appear to be the norm for the Mission's nurses.

However, employment by the city health department was clearly not an entirely progressive step for visiting nurses either. At best, it would appear that they simply exchanged one type of employer for another. The Mission's precarious financial situation

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[114]Buhler-Wilkerson. *False Dawn.*

had kept nursing salaries low in comparison to those offered by other agencies such as the VON and the city health department. However, nurses employed by the health department found themselves at the bottom of the organizational hierarchy once all child hygiene services were centralized under Douglas's control. After the formal organization of the Child Hygiene Division in 1914, all reports from the nurses were filtered by Tustin and Douglas before being forwarded to the upper echelons of the health department. Nurses were, in fact, rendered even more distant from those in positions of authority than they had been when employed by female social reformers.

While the status and autonomy of child hygiene nurses could be as readily curtailed in either voluntary agencies or the civic health department, nursing's attainment of professional status was hampered from within as well. Unlike medicine, nursing suffered from the gnawing sense that its training programs did not adequately prepare graduates for a community based practice in preventive health programs. Nursing leaders bewailed both the profession's lack of preparation for public health roles, and the lack of recognition by others of the potential contribution nursing could make to the new discipline of public health. Even social workers, it was claimed, were staking out roles which might just as readily be filled by nurses. Nurses continued to be "only the handmaiden of the doctor rather than a coöperator and counsellor with the practitioner of preventive medicine."[115]

Public health based projects of moral regulation led by health care professionals and directed towards the poor and immigrant populations of large urban centers

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[115]Crandall, "The Relation of Public Health Nursing," 231.

ultimately met with limited success. While it is true that the infant mortality rate was brought under control, this achievement more likely resulted from the provision of safe modified cows milk formula to poor families rather than from health education programs directed at "ignorant" mothers. What is certain is that the increased risk of disease and poor health experienced by the urban poor did not go away. Because the sanitary, bacteriological, and health education interventions of the public health departments did not address the fundamental problem of poverty experienced in communities divided by ethnicity and class, other health issues rooted in the same dynamics arose to take the place of infant mortality. Maternal mortality, tuberculosis, sexually transmitted diseases, addictions, and violence claimed, in turn, the moral terrain vacated by infant mortality. The specific health issue changed over time, but the moralization of those afflicted with these problems did not.

As was the case with projects of moral regulation elsewhere, the impetus to reduce the incidence of infant mortality arose from the middle-class, elite, and professional reformers in Winnipeg.[116] Elite women were particularly concerned about this issue and it was their pioneering efforts in founding a Milk Depot, a visiting nursing program, a child hygiene program, and a Little Nurses' League that laid the groundwork for the incorporation of these programs within governmental agencies. However, it must be acknowledged that it was as much fear of "the other" as compassion for their suffering that motivated their actions. In the end, female social reformers could not command the financial resources necessary to sustain the programs they had founded, and they were

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[116]Hunt, *Governing Morals*, 2.

forced to turn to male bureaucrats in order to ensure their continuation.

Despite the patriarchy and condescension embedded in Winnipeg's efforts to combat infant morality, there is evidence that poor and immigrant mothers gratefully accepted the assistance offered by both voluntary and civic organizations devoted to combatting infant mortality. The rapid growth in case loads, both for the Child Hygiene nurses and for the Milk Depot, attest to the extent to which these services met a significant need in the community. Grateful parents who could not afford to pay for these services at the time they were provided often did so months, or even years later. The Scott Mission's Board minutes record a poignant example of a father's gratitude for the nursing care provided to his sick child. In 1922, Mr. S. removed the screens and put on the double windows at the Mission's Home at 99 George St. at no charge. This was done, stated the Board Minutes, out of gratitude for the nursing care that Estella Clark, one of the Mission's Child Hygiene nurses, had provided to his child.[117] Clark had resigned from the Mission's staff in 1916.[118]

To the occasional surprise of Douglas and others, immigrant families were sometimes more responsive to initiatives intended to combat infant and child mortality than were their native born and Anglo-Celtic counterparts. It was, reported Douglas, "the strangest thing" that immigrant families were more conscientious about registering the

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[117]AM, The Mission papers, MG 10, B9, Box IV, Board of Management Minutes, December 11, 1922.

[118]AM, The Mission papers, MG 10, B9, Box IV, Board of Management Minutes, September 11, 1916.

birth of their children than were their Canadian counterparts.[119] Perhaps it was not so strange when one realizes that the most effective strategy to ensure a visit from the Child Hygiene Nurse was to register the newborn's birth. It is evident that many poor and immigrant mothers were willing to endure the patriarchy, professional scrutiny, and moralization embedded in Winnipeg's Child Hygiene programs if it meant that their infants had a better chance of surviving their first year of life.

In the final analysis, however, Winnipeg's efforts to combat infant morality must be viewed as a mixed blessing for those who were the targets of public health initiatives to reduce infant mortality. There is little doubt that the measures enacted under the leadership of elite women and male public health professionals saved the lives of many children. But, at what cost? Alan Artibise has characterized Winnipeg's politicians as callous and indifferent to the suffering of its poor and immigrant citizens. This was not entirely the case. A callous and indifferent city would not have responded to the crisis of 1912 by instituting a program that would, in the space of six years, consume twenty-five percent of the health departments' operating budget. It would more likely have done nothing. But a city that feared the impact of foreigners on the political and social fabric of the community and that sought to maintain the prevailing social order might respond in this manner. Certainly a social and political elite that sought, above all, to control and regulate the behaviours and beliefs of those they could not accept as their equals would do so. The provision of a Child Hygiene program was, from this perspective, a far less expensive solution to the problems associated with urban poverty than the provision of an

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[119]CWA, Health Department, *Annual Report* (1917), 6.

adequate income for Winnipeg's poor and destitute families. The reduction of Winnipeg's appalling infant mortality rate, a success story for its health department and its staff of professional civil servants, was achieved at a significant cost. And the highest price of all may have been paid by those who received social assistance and health education instead of economic justice.

Conclusion

This chapter has traced the origins of the child saving movement in Britain, the United States, and Canada and identified the role that elite female social reformers played in its founding. Examining Winnipeg as a specific case study, it has identified and discussed the maternalist origins of the Little Nurses' League, child hygiene program, and milk depot and the leadership role that women played in demonstrating their effectiveness. Taking advantage of a gendered ideology that gave women authority over child rearing practices, female social reformers founded voluntary visiting nursing programs that facilitated the "woman to woman" efforts to reduce infant mortality that were a hallmark of the late nineteenth and early twentieth century. By the second decade of the twentieth century, two developments reshaped this gendered division of labour and gave male bureaucrats and physicians greater authority over the care and nurturing of healthy children. The ascendency of "scientific motherhood" made physicians, particularly pediatricians, the leading authorities in matters related to infant and child health. At much the same time, the state became interested in the fate of its future citizens and created child hygiene programs within civic and provincial health departments. These developments reshaped the boundaries between men's and women's work in the public

sphere and diminished the autonomy of female-led voluntary "woman to woman" programs. Within this new paradigm, visiting nurses also lost autonomy as their work came under the increased scrutiny of male physicians and bureaucrats. Finally, although infant mortality rates were significantly reduced by the end of the First World War, this chapter analyzes the impact of Winnipeg's child hygiene programs on the population it served and suggests that the education of "ignorant" mothers may not have had as much impact on the program's success as did the provision of material necessities such as safe, affordable infant formulas.

Chapter 8

Public Health in the Welfare State: Winnipeg's Public Health System in the Aftermath of the Buck Report, 1941-1945

Introduction

Although local fiscal policies and the professional projects of medicine and nursing played an important role in reshaping the original mandates and administrative autonomy of both the Scott Mission and the VON, economic and political circumstances during the inter-war years had the most profound impact on these organizations. The decade between 1930 and 1939 is remembered primarily for the economic crisis that tore the fabric of Canadian society and transformed its political landscape. The "Great Depression" revealed fundamental flaws in the global economy that had existed since the First World War.[1] Affected by widespread destitution, unemployment, and social unrest, many industrialised nations were forced to embark on a painful re-assessment of the basic tenets of capitalism and of the state's responsibility to its citizens. It was not possible, in Blair Neatby's words, to go back: "A return to the good old days was not good enough; the good old days had culminated in disaster."[2] The search for a solution to the consequences of unbridled capitalism took individual nations down very different paths. Canada's solution to the economic and social crisis of its "Lost Decade" lay in a

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[1]Thompson and Seager. *Canada 1922-1929,* 193-197. The impact of the 'Great Depression' on Canadian political and social life is the subject of many monographs. See, in addition to Thompson and Seager: Broadfoot, *Ten Lost Years*; Francis and Palmer, *The Prairie West*, 2nd ed; Gray, *The Winter Years*; Friesen *The Canadian Prairies*; Gibbins, *Prairie Politics & Society*; Laycock, *Populism and Democratic Thought*; Neatby, *The Politics of Chaos.*

[2]Neatby, *The Politics of Chaos,* 24.

fundamental renegotiation of the relationship between its federal government, the provinces and the local governments and on the creation of a publicly funded health system that removed financial barriers to health care and the basic necessities of life.[3]

Although the creation of an improved social safety net was motivated by a desire to protect Canadians from the consequences of widespread economic failure and to ensure that similar events would not happen in the future, the emergence of a more interventionist government imposed stricter limits on women's autonomy and their participation in publicly funded health and welfare programs. As recipients of these services, women were often poorly served by the patriarchal administrative structures of government agencies. Female social reformers, who had pioneered public health programs as voluntary and charitable enterprises, were also excluded from all but token participation in the development and delivery of similar programs under the auspices of the state.[4]

This chapter begins with a brief review of the transformations in federal and provincial powers which occurred in the aftermath of the Great Depression. It then analyses the impact of these negotiations on the provision of health and welfare services in western Canada. Finally, it will analyze the impact of the 1945 Manitoba Health Plan on Winnipeg's two female led visiting nursing associations and on the all female nursing

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[3]For a general discussion of federal/provincial responsibilities and the process by which these were renegotiated during the 1930s and 1940s, see footnote 1. See also: Ferguson and Wardhaugh, 'Impossible Conditions of Inequality', 551-583.

[4]In relation to the impact of the Canadian welfare programs on women, see, for example: Arnup, Lévesque and Pierson, eds., *Delivering Motherhood*; Christie, *Engendering the State;* Little, *No Car, No Radio*.

staff of the city of Winnipeg's health department.

Creating the Welfare State:
Public Health and Welfare Before and After the Rowell-Sirois Commission

Under the provisions of the British North America (BNA) Act, responsibility for health and welfare services lay with the provinces. Following poor law traditions that dated back to Elizabethan England, the provinces, in turn, placed the major burden for the provision of services to the indigent on local governments. Unfortunately, this arrangement placed the heaviest financial burden on local governments, which were least able to generate the tax revenues required to fulfill this mandate. Cities and municipalities were often hard pressed to meet the needs of their citizens during periods of high unemployment, epidemics, and other emergencies. The influx of large numbers of immigrants in the early twentieth century only served to exacerbate this problem. Although not directly involved in immigration policy, local authorities and charities were often forced to deal with the significant social and health care needs experienced by newcomers. Reasoning that the government that had encouraged their settlement in Canada should be responsible for the health and welfare costs incurred by immigrants who had fallen on hard times, local authorities put considerable pressure on the federal government to take some responsibility for their care. Agencies such as the Scott Mission off-set part of the cost of providing charitable nursing care to non-naturalized immigrants by billing the federal government. This strategy forced the senior level of government to acknowledge that it had at least a limited role in providing essential health and welfare services to a specific segment of Canadian society whose entitlement to local charitable

support was tenuous at best. However, the process of recovering these costs from the senior level of government was time-consuming, frustrating, and often unsuccessful.[5]

The federal government's involvement in health and social welfare programs increased in the aftermath of the First World War. Unlike immigrants, whose claim on the federal government flowed from their status as non-citizens, returning veterans demanded a federally coordinated system of social and medical assistance because they *were* citizens. Further, they asserted that they were citizens who "had earned support at the cost of their own pain and blood." [6] Their sacrifice, they argued, entitled them to a level of support beyond the uncertain and idiosyncratic assistance likely to be provided by local authorities. Canadian veterans' associations forced a reluctant federal government to provide a number of nationally coordinated programs to ease the transition of the able-bodied returning soldier into civilian society and to provide social and medical support for those whose physical and psychological injuries precluded full reintegration into civilian life.

In the years immediately following the First World War, provincial governments also redoubled efforts to improve the lot of their citizens. Provincial spending for highway construction and public schools increased. In the absence of a comprehensive national program, many provinces also underwrote mothers' allowance and old age

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[5]AM, The Mission papers, MG 10 B9, Box I, Correspondence. Letter from D.W. Bole to George Minty, Solicitor for the Mission dated April 14, 1905; letter from the Commissioner of Immigration to Margaret Scott, dated May 30, 1905; letter from D.W. Bole to Louise Minty, Secretary of the Board of Management, dated May 2, 1905; letter from Department of the Interior to Louise Minty dated November 14, 1905.

[6]Morton and Wright, *Winning the Second Battle,* 64.

pension programs.[7] However, the Great Depression was the single most significant factor that forced a renegotiation of federal and provincial responsibilities. A decade of industrial and agrarian economic failure conclusively demonstrated the limited capacity of local and provincial governments to respond effectively at a time when unprecedented numbers of Canadians turned to them for assistance. Western Canadian provinces, cities, and rural municipalities were particularly hard hit by a combination of decreased revenues and increased costs. Public coffers were drained by expenditures to provide medical care and welfare services to the unprecedented number of citizens rendered destitute by the double blow of drought and economic failure. In 1936, Premier Bracken of Manitoba informed Ottawa that his government was close to bankruptcy because its revenues had fallen below the level necessary to maintain services. Saskatchewan faced a similar economic crisis.[8] The situation within many local governments was, if possible, even more desperate. Tax revenues hit an all-time low as hard-pressed rate payers simply surrendered their property rather than pay the taxes.[9]

During an era when, through "no fault of their own," millions of previously productive and independent families were forced to turn to the government for support, Canadians were less willing to accept the judgmental attitudes and moralising strictures

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[7]Thompson and Seager, *Canada 1922-1929,* 133.

[8]Granatstein, *The Ottawa Men,* 59-61.

[9]Thompson and Seager, *Canada 1922-1929.*

that accompanied the meagre charity meted out by local authorities.[10] Poverty on this scale could not be explained away as the consequence of personal character defects or bad luck. If there was immorality lurking beneath the widespread unemployment and destitution of the era, it could no longer be attributed to the unemployed and dispossessed.

In response to the ever deepening social and economic crisis, several time-limited federal grants, which increased provincial and local funding without altering the existing distribution of federal and provincial powers, were offered. For example, the Unemployment Relief Act (1930), enacted by the Bennett government, provided fifty percent of the funding for public works projects. Each of the other levels of government was expected to provide twenty-five percent of the funds for the program. Federal funds were distributed to the provinces on a per capita basis rather than on need. The provinces, in turn, distributed the funds according to which local governments were able to contribute their share of the funds to create public works programs. Needless to say, this program did not benefit provincial and local governments in the greatest need of assistance because they were unable to contribute the necessary matching funds. The federal public works programs ended in 1932. Although they failed to make any significant difference to the plight of unemployed citizens and cash-starved local and provincial governments, these programs effectively demonstrated the limited capacity of any level of government to respond to the economic crisis under the constraints of the

[10]For an extended discussion of the impact that the widespread unemployment of the 1930s had on the creation of a national unemployment insurance system, see: Struthers, "No Fault of Their Own".

BNA Act. Ultimately, this jurisdictional impasse encouraged federal/provincial negotiations regarding a formal constitutional amendment to enable all levels of government to respond more effectively to the health and social welfare needs of all Canadians.[11]

The Royal Commission on Dominion Provincial Relations (the Rowell-Sirois Commission) was struck in 1937 to evaluate the economic and social impact of the current constitutional arrangements and to recommend how these might be altered to create a more effective and equitable social welfare system in Canada. The Commission tabled its report in 1940. Acknowledging that provincial and local governments had insufficient resources to fund the costs of a comprehensive social insurance program, it recommended that, in return for the transfer to Ottawa of jurisdiction over income and corporate taxes and succession duties, the federal government should assume responsibility for unemployment insurance and old age pensions. However, the Commission also recommended that the provinces retain responsibility for public health programs and medical care.[12] Maintaining provincial jurisdiction over these services was tied to the assumption that the medical care of indigent persons would continue to be the mandate of provincial welfare systems. The Commission believed that transferring all but the indigent to a federally funded health insurance program would compromise the

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[11]See: Thompson and Seager, *Canada 1922-1929,* 207-212. For additional information on the renegotiation of federal/provincial powers, see: Cassidy, *Public Health & Welfare Reorganization*; Granatstein, *The Ottawa Men*; Neatby. *The Politics of Chaos*; Owram, *The Government Generation*; Struthers, *"No Fault of Their Own"*.

[12]Gray, *Federalism and Health Policy,* 22; Owram, *The Government Generation,* 242-43; Taylor, *Health Insurance and Canadian Public Policy,* 10-12.

capacity of the provinces to effectively coordinate health services.[13] "[T]he desirability of co-ordinating all medical services within the provinces under provincial control," stated the Report, "is a strong argument against the establishment of any scheme which would remove any large group [i.e., the general population or non-indigents] within the province from provincial responsibility, as a Dominion health insurance scheme would do."[14]

The recommendations of the Rowell-Sirois Commission signalled a significant shift in the way that unemployment was conceptualized in Canadian society. No longer viewed as an individual failure or a local problem, federally funded financial support during times of unemployment had become the right of the male wage-earner.[15] Publicly funded health care, on the other hand, was still conceptualized as a local responsibility that only the poor would need.

The restructuring of the Canadian government's jurisdiction over health and social

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[13]Taylor, *Health Insurance and Canadian Public Policy,* 11.

[14]Royal Commission on Dominion-Provincial Relations, *Report*, Book II, 39.

[15]Linda Gordon argues that social insurance programs in the United States were stratified, with those based on entitlement (rights) being placed under the jurisdiction of the federal government, and those based on need remaining at the local level. Thus, federal programs such as unemployment insurance were accessible to all who qualified for them, but state and local programs such as mother's allowance were often discriminatory and subject to qualifying criteria such as means tests. Within the Canadian context, Nancy Christie, in her analysis of the Canadian welfare state, puts forth a similar argument. The advent of unemployment insurance in 1940, she argues, created a two-tiered welfare system in Canada. Contributory programs such as unemployment insurance became federal responsibilities. Programs to support women, such as mothers' allowances and widows' pensions, were relegated to provincial relief programs based on need. See: Gordon, *Pitied But Not Entitled*; Christie, *Engendering the State*. Both writers evidently assume that those benefiting from unemployment insurance programs do not experience the stigma associated with dependence on other forms of social assistance.

services, however, did not end with the Rowell-Sirois Commission. Those who had lobbied for nationally funded and coordinated health insurance and welfare programs continued to press for changes to the current system. These issues quickly became integrated into larger efforts to create a comprehensive plan for the post-war period. Two major federal government reports, released in March 1943, signalled the federal government's continued interest in creating a comprehensive network of social programs in Canada. The Report on Social Security for Canada [the Marsh Report] introduced "the first comprehensive plan for social security emanating from Ottawa."[16] The Report of the Advisory Committee on Health Insurance [the Heagerty Report] contained both recommendations for the creation of a national health insurance program and a draft bill outlining the provisions of this program.[17] Anticipating constitutional changes to enhance the delivery of both social services and health programs in Canada, provincial governments began to lay their own plans to shape the nature of publicly funded programs within their boundaries.

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[16]House of Commons Special Committee on Social Security. *Report of the Advisory Committee on Health Insurance*, March 1943; Owram, *The Government Generation*, 290; Royal Commission on Dominion-Provincial Relations, *Report*, Book II, 1940.

[17]House of Commons Special Committee on Social Security. *Report of the Advisory Committee on Health Insurance*, March 1943.

The Reorganization of Health Care Services in Manitoba, 1941 - 1945: The Buck Report and the Manitoba Health Plan

Western Canadian ideas about the role that the state should play in the lives of its citizens had a significant impact on the ongoing federal/provincial negotiations related to the funding and organization of health care programs. Provincial and territorial governments had long been obliged to respond to the health care needs of newly arrived settlers. In rapidly growing urban centres, provincial governments provided grants to support the work of local governments and charities. In sparsely populated rural districts where medical services were not readily available and local governments were not yet organized, provincial governments were forced to take direct responsibility for the provision of health care services. The subsistence economy of these recently settled districts meant that many families had no income to pay for medical services even when these services were within geographic reach. This made the recruitment and retention of qualified physicians very difficult. While it was not unusual for local governments in Canada to offer physicians some form of remuneration for services rendered to indigent patients, Saskatchewan and Manitoba actually enacted legislation enabling municipalities to pay the salaries of physicians. Municipal doctor schemes were a uniquely western Canadian solution to the problem of creating equal access to medical services.[18] In

[18]In 1915, the rural municipality of Sarnia, SK became the first local government in Canada to subsidize the salary of a local physician to encourage him to remain there rather than relocate to a larger community. Although this was not strictly legal, the Saskatchewan government watched this experiment with great interest, and in 1916, passed legislation enabling local governments to subsidize the salaries of local physicians. In 1919, the legislation was amended to enable municipalities to pay the full salaries of municipal doctors. Manitoba passed similar legislation in 1921. See: Carr and Beamish, *Manitoba Medicine,* 94; Houston, *Steps on the Road to Medicare,* 29-20;

addition to encouraging physicians to locate in sparsely settled areas of the west, publicly funded medical care also overcame the reluctance of citizens to seek medical attention if they could not pay for the service. Another response to the lack of medical services in rural areas of the prairie provinces was the provision of health services by nurses. Alberta, for example, established its District Nursing Service "to meet needs for midwifery and emergency medical treatment in the frontier communities of this prairie province with neither physicians nor hospitals."[19] The province paid the nurses' salaries, provided their supplies and equipment, and underwrote the cost of providing services to indigent patients. Participating local communities were responsible for the nurses' accommodation, water, fuel, and transportation.[20]

The prairie provinces also established hospitals financed by municipal tax revenues rather than annual provincial grants. Municipal hospital acts in Saskatchewan and Alberta enabled local governments to raise taxes for these purposes. Adjacent municipalities were also empowered to create Union Hospitals, which enabled small or financially strapped municipalities to join forces in order to raise sufficient revenues to construct and operate a hospital.[21]

MacTaggart, *The First Decade*, 9.

[19]Richardson, "Political Women, Professional Nurses," 25.

[20]Richardson, "Political Women, Professional Nurses," 25-50.

[21]In 1916, the provinces of Saskatchewan and Alberta enacted legislation permitting adjacent municipalities to join forces to construct and operate hospitals. The first Union Hospital was located at Lloydminster, a prairie community that straddles the boundary between these two provinces. See: Cassidy, *Public Health and Welfare Reorganization* , 285, 308; Houston, *Steps on the Road to Medicare,* 38; MacTaggart,

Finally, the idea of a government-sponsored medical and hospital insurance program was pioneered in western Canada. Physician-sponsored non-profit medical insurance programs had been established in Manitoba and Saskatchewan in the waning years of the Great Depression.[22] However, British Columbia shifted the ideological terrain significantly when, in 1935, the Liberal government of T.D. Patullo proposed a publicly funded health insurance program for its citizens. Unfortunately, the plan was scrapped in 1937 just three weeks prior to its implementation because the province did not have the financial resources to support it.[23]

In Manitoba, potential changes in the organization and financing of health and welfare services at the federal level were watched with considerable interest by key members of the Department of Health and Public Welfare, including Deputy Minister F. W. Jackson. Described as "an able and progressive deputy minister," Jackson was deeply committed to preventive medicine, the provision of publicly funded medical and public health services, and the extension of these services to rural and northern Manitoba.[24] After graduating from the Manitoba Medical College in 1912, Jackson practised medicine in rural Manitoba until 1927. In 1928, at the request of the newly created Department of

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The First Decade, 11.

[22]Carr and Beamish, *Manitoba Medicine,* 134; MacTaggart, *The First Decade*, 12-13.

[23]Cassidy, *Public Health and Welfare Reorganization,* 90-92; Taylor. *Health Insurance and Canadian Public Policy*), xiv; Thompson and Seager. *Canada 1922-1929,* 293.

[24]Cassidy, *Public Health and Welfare Reorganization,* 323.

Health and Public Welfare, he conducted a health survey of rural Manitoba. After completing a Diploma in Public Health at the University of Toronto in 1929, Jackson entered the civil service as Director, Division of Disease Prevention of the Department of Health and Public Welfare. In 1931, he was appointed Deputy Minister.[25]

Jackson played a major role in enlarging the provincial government's role in the provision of health care to its citizens. As a highly respected expert in public health and preventive medicine, Jackson was aware of the vigorous debates about the role of the modern state in the provision of health and welfare services, and of the various alternatives proposed for the financing of these programs. Jackson also enjoyed extraordinary decision-making powers within the Department. The Minister, Ivan Schultz, who was also the Provincial Attorney-General, confined his activities to the approval of significant changes in policy and "wisely" permitted his Deputy to administer the Department on a day to day basis.[26]

The period between 1936 and 1944 was one of intense activity for the Manitoba Department of Health and Public Welfare. Unlike many other jurisdictions in Canada,

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[25]The biographic information on F. W. Jackson included here is located in the Legislative Library, Province of Manitoba in its Biography Vertical Files, and in its Biographical Scrapbooks (B10, p. 28, 142; B11, p. 91, 142). Beamish and Carr also refer to Jackson's 1928 public health survey, stating that he drove 8000 miles around Manitoba in the course of completing this work. See: Beamish and Carr, 81. The name of the report that Jackson submitted to the provincial government after his survey is not identified in any of the documents cited.

[26]These, and other comments about the organization and management of the Manitoba Department of Health and Public Welfare are found in: Buck, *Public Health in Manitoba*, 6-12. Like Cassidy, Buck was impressed with Jackson's leadership in the Department, describing him as "an extraordinarily capable leader and administrator" and "a man of real vision."

health and welfare services were combined under one Minister.[27] Thus, the same senior administrators were compelled to anticipate and respond to the complex federal/provincial negotiations regarding the funding and administration of health and welfare programs in Canada. Under Jackson's leadership, the Department prepared to respond to the eagerly anticipated expansion of the Canadian welfare state. In order to assess the current health status of Manitobans, two studies were commissioned by the provincial government in the early years of the Second World War. In 1940, the Rockefeller Foundation conducted a study of maternal welfare in Manitoba.[28] In 1941, after two years of discussion, the Department of Health and Public Welfare invited Dr. Carl Buck of the American Public Health Association to conduct a survey of public health activities in the province.[29] Both reports, but particularly the Buck Report, were central elements in Jackson's efforts to restructure health care services in Manitoba and enable the province to take full advantage of federal funding that both he and Premier Garson anticipated would flow in support of provincial health programs in the post war era.

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[27]Buck, *Public Health in Manitoba*, 9. In a speech before the Manitoba Legislature on March 6, 1945, Hon. Ivan Schultz stated that Manitoba was the first province to combine the portfolios of health and welfare, and that, since then, five other provinces and the federal government had followed suit. See: AM, Minister of Health Files, GR157 H001, File No. H-8-5-2: Health Services General: "Health and Welfare Activities, 1944".

[28]Buck, *Public Health in Manitoba*, 66.

[29]AM, Executive Council, Office of the Premier, G64, File 26, Department of Health and Public Welfare. Undated memo from F.W. Jackson to Premier John Bracken.

The Re-organization of Public Health Services in Winnipeg

Although the long-term focus of the provincial health department was the improvement of health services to rural Manitoba, all Winnipeg-based health care agencies and charitable organizations receiving grants from the provincial government were also reviewed by Buck. The Buck Report, therefore, re-shaped public health and visiting nursing services within the city, particularly those offered by the city health department, the VON, and the Mission. The implementation of Buck's recommendations foreshadowed subsequent developments in the delivery of public health services to rural Manitoba.

The city health department was the recipient of mixed reviews. While acknowledging the credentials and leadership qualities of the medical health officer and his assistant, Buck stated that "the Department is burdened through tradition and inheritance, with archaic and outmoded programs in several of its important activities."[30] Of these, Buck was most critical of the public health nursing program which, he stated, possessed only one strength: "the enthusiasm and untiring efforts of the nurses themselves."[31]

In accordance with Buck's recommendations, the department's public health nursing program was reorganized to bring it more in line with public health nursing

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[30]Buck, *Public Health Activities in Winnipeg*, 46.

[31]Buck, *Public Health Activities in Winnipeg*, 30. Olivia T. Peterson, Director of Public Health Nursing for the Minnesota State Department of Health, was brought in as a consultant to assess the state of public health nursing in Winnipeg. Peterson had direct contact with nurses and administrators from the Health Department, the Mission, and the VON, and evidently authored much of the material analysing their nursing programs.

programs in other health departments across Canada and the United States. A generalist public health nursing program was established, so that instead of having separate tuberculosis, child hygiene, and school health nursing programs, the same nurse delivered all programs within a district of the city.[32] These changes had actually been under consideration within the health department as early as 1938. Dr. M. Lougheed, the city's medical health officer, had made a formal proposal to the Health Committee in early 1940 that the city's decentralized public health nursing programs be amalgamated. In a letter to the Committee, Lougheed stated that: "Our Health Department is the only one of all the Provincial, State or City Departments, of which I have knowledge, not having a centralized Division of Nursing.[33] Because much of the groundwork had already been laid, the actual transfer of the Winnipeg School Board nurses to the health department was accomplished in the fall of 1941, only months after the release of Buck's report.[34]

The Buck Report also recommended that the Milk Depot, the centrepiece of the city's child hygiene program from its inception, be closed. As had been the case with the reorganization of the department's public health nursing program, this action had been

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[32]Buck, *Public Health Activities in Winnipeg*, 33-34.

[33]CWA, Health Committee, File H1654. Letter from M.S. Lougheed to the Health Committee dated January 10, 1940.

[34]CWA, Health Committee, File H1654, A joint committee, composed of representatives from the Winnipeg School Board and the City Health Department had been appointed to consider the amalgamation of these services in September, 1938. A proposed resolution for the amalgamation of these programs identified a target date of September 1, 1941 for this to be accomplished.

under active consideration since the fall of 1940.[35] In October 1941, the Milk Depot was transferred to Children's Hospital. The health department retained responsibility only for well baby clinics and home visiting services.[36]

The supervision of the newly formed generalist public health nursing program was also transformed in the wake of the Buck Report. Since its inception in 1914, the Bureau of Child Hygiene had been part of the Food and Dairy Division. P. B. Tustin, head of the Division, supervised the child hygiene nurses. Tustin was a lay male bureaucrat with no formal preparation in nursing, health education or child health. He was succeeded in 1919 by A. G. Lawrence, who previously had held the position of statistician in the Clerical and Vital Statistics Division. In a similar arrangement, the city's tuberculosis nurses were supervised by the Chief of the Communicable Diseases Division, who was a health inspector.[37] Buck recommended that the new public health nursing program be supervised by a nurse rather than a lay person, stating that "adequate nursing supervision is generally agreed to be a basic essential of effective modern public health nursing service [sic]."[38] This recommendation had evidently not been anticipated and Departmental officials scambled to locate a suitable candidate to fill the newly created position of Director of

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[35]CWA, Health Committee, File H1398. Letter from M.S. Lougheed to the Committee on Health dated September 4, 1940.

[36]CWA, Health Committee, File H1398. Letter from Dr. Bruce Chown, Superintendent of Children's Hospital to M.S. Lougheed dated August 19, 1941; letter from M. Lougheed to the Committee on Health dated September 3, 1941; Council Minutes of October 14, 1941, Item 924.

[37]CWA, Health Department, *Annual Report* (1914); *Annual Report* (1919).

[38]Buck, *Public Health Activities in Winnipeg*, 31, 34.

Public Health Nursing. No nurse currently employed by the department was qualified for the position, which Buck recommended should only be offered to a nurse with a science degree or equivalent and considerable supervisory experience.[39] After a difficult interval during which the fledgling generalist public health nursing program "got into difficulties regarding the arranging of work for the coming school term," the city arranged for the "loan" of an experienced nursing superintendent from the Toronto Department of Public Health.[40] Miss P. Roberts, initially appointed to this position until June 30, 1942, actually served until early 1943. She was succeeded by Gertrude Hall, a graduate of the Grace and Winnipeg General Hospital Schools of Nursing, who held a diploma in public health nursing from McGill University.[41]

In his report, Buck also stated that the department did not employ enough public health nurses to provide the level of services characteristic of a "modern" health department. In addition, the nurses currently employed by the health department and the Winnipeg School Board did not meet current professional standards for public health nursing. Ninety three percent had no training in public health.[42] To simultaneously

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[39]Buck, *Public Health Activities in Winnipeg*, 35, 41.

[40]CWA, Health Committee, File H1654. Letter from M.S. Lougheed to the Committee on Health dated September 3, 1941; letter from Elsie Hickey, Director, Division of Public Health Nursing, Department of Public Health to M.S. Lougheed dated September 20, 1941; letter from M.S. Lougheed to the Committee on Health dated September 24, 1941.

[41]CWA, Health Committee, File H1654. Letters from M.S. Lougheed to the Committee on Health dated September 24, 1941; March 16, 1942; April 28, 1943.

[42]Buck, *Public Health Activities in Winnipeg*, 8.

address deficiencies in both the number and the qualifications of city public health nurses, Buck recommended that the current staff complement of 29 public health nurses be increased to at least 50, and that newly hired nurses be required to possess a one year post graduate diploma in public health nursing.[43]

The performance of the VON and the Scott Mission was also scrutinized as part of the survey. Buck was particularly critical of the long standing local agreement that the VON would provide nursing care to those who could afford to pay fees, and that the Mission would serve those who could not. The distinction between charitable and non-charitable bedside nursing services was described as "an unnatural one which is inimicable [sic] to the best interest of the patient," and which "results in a certain amount of duplication of effort, loss of time, and embarassment [sic] to the patient."[44] In addition, Buck "frankly condemned" the Mission's practice of accepting five to six student nurses for training in visiting nursing, and of allowing students to conduct home visits without the supervision of qualified staff nurses.[45] Citing the precarious financial state of the Mission, and its inability to recruit and retain qualified nurses, Buck concluded that "the prestige and splendid reputation of the Margaret Scott Nursing Mission can best be maintained for the future by combining its services with those of the Victorian Order of Nurses."[46] In contrast, the VON received high praise for employing "by far the best

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[43]Buck, *Public Health Activities in Winnipeg*, 7, 40.

[44]Buck, *Public Health Activities in Winnipeg*, 28.

[45]Buck, *Public Health Activities in Winnipeg*, 29.

[46]Buck, *Public Health Activities in Winnipeg*, 30.

formally trained group of public health nurses" in Winnipeg.[47] Over one-half of the nurses working with the VON had graduated from a one year post-diploma training program in public health nursing. All but one of the remaining staff had certificates from somewhat shorter training programs. The organization was also commended for the high qualifications of its nursing supervisors, its planned program of staff education, and its record-keeping system.[48]

The VON took several months to declare whether or not they would accept sole responsibility for all bedside nursing services in Winnipeg. They were particularly careful not to act until after the Scott Mission had responded to the Buck Report.[49] In her address to the Mission's Annual Meeting on January 31, 1942, Mrs. Joseph Harris, the Board President thanked the VON for their tact and consideration. "The Victorian Order knows," she stated, "how this tears at the very roots of our being. We appreciate their understanding."[50] The VON did not officially accept responsibility for the sole provision of bedside nursing services in Winnipeg until March 11, 1942, following the passage of a resolution of the Health Committee of the Council of Social Agencies stating that they were in support of this action.[51]

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[47]Buck, *Public Health Activities in Winnipeg*, 7-9.

[48]Buck, *Public Health Activities in Winnipeg*, 9-13.

[49]VON, Manitoba Branch, Minutes of June 18, 1941, October 8, 1941, November 12, 1941; Executive minute of September 18, 1941.

[50]AM, The Mission papers, MG 10, B9, Box VI, *The Thirty-Seventh Annual Report* (1941) 7.

[51]VON, Manitoba Branch, Minutes of March 11, 1942.

The VON also awaited the outcome of discussions regarding the financing of the free nursing services that had previously been provided by the Mission. In late 1941, the local media reported that a grant of $6000.00 had been requested from the city's finance committee to finalize the amalgamation of the two visiting nursing agencies during the next budget year. If obtained, this would be an increase of $2400.00 over city grants provided to both agencies in 1941.[52] Unfortunately, in 1942, the VON received only $3200.00 from the city to support its work. This, in addition to the $2000.00 provincial grant, netted the VON $800.00 less in total government funding than they had hoped to receive from the city alone. In 1943, the first year in which the VON operated as the sole visiting nursing agency in Winnipeg, its total grant from both sources remained at $5200.00. In essence, they had taken on the responsibility for providing all bedside nursing services in Winnipeg for a net saving to the local and provincial governments of $1200.00 per year (Table 8-1).

Table 8-1: Government Funding for Visiting Nursing Services, 1941 - 1943

Year	VON		Mission		Total
	City	Prov.	City	Prov.	
1941	0.00	585.00	3600.00	675.00	4860.00
1942	3200.00	2000.00	1200.00	0.00	6400.00
1943	3200.00	2000.00			5200.00

Sources: AM, The Mission Files, MB10, B9, Box VI, *The Thirty-Seventh Annual Report* (1941)), *The Thirty-Eighth Annual Report* (1942), *The Thirty-Ninth Annual Report*, 1942, VON, Manitoba Branch, *Annual Report* (1941), *Annual Report* (1942); *Annual Report* (1942).

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[52]This article is pasted inside the front cover of the 1941 Mission *Annual Report* and in the VON Minute Book, 1941-1945 on page 11, near the November/December 1941 minutes.

The VON suffered other significant losses during the re-organization of public health services in Winnipeg. Buck recommended that, after amalgamation with the Mission, the VON's mandate should include only the provision of bedside nursing services in the home and attendance at home deliveries.[53] This, in effect, excluded the further participation of the VON in prenatal and postnatal home visiting programs, health education, and the provision of child welfare services. These programs were transferred either to the city health department or the newly formed provincial health units in suburban Winnipeg.[54]

The closure of its child health conferences was a particularly difficult issue for the VON. In cooperation with the provincial health department, they had provided very successful bi-monthly child health conferences in the Winnipeg suburbs of Fort Garry, St. James, and East Kildonan for many years.[55] In his report, Buck had specifically recommended that all child health conferences that did not have physicians in attendance should be closed.[56] Although this recommendation had been primarily directed to the city's health department, the VON's child health conferences were also staffed primarily by nurses, with physicians attending only on an irregular basis. The VON consulted with

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[53]Buck, *Public Health Activities in Winnipeg*, 37-38.

[54]In the long run, Buck recommended that the City Health Department ultimately undertake responsibility for all public health programs in Greater Winnipeg. See:Buck, *Public Health Activities in Winnipeg*, 36; VON, Manitoba Branch, Minutes of December 10, 1941.

[55]VON, Manitoba Branch, *Annual Report* (1941) 4.

[56]Buck, *Public Health Activities in Winnipeg*, 54.

Elizabeth Russell, the Director of Public Health Nursing for the province of Manitoba, and Maude Hall, acting Chief Superintendent of the National VON. Both nursing leaders concurred with Buck's recommendation that "conferences without a doctor in attendance were of negative value."[57] Reluctantly, the VON announced that it would close its three child health conferences as of March 15, 1942.[58] However, well aware that its long-term survival depended upon its ability to create new health care initiatives to meet unmet needs in the community, the Board also noted that "[W]hether we might in future develop other types of group instruction was a matter for the new executive to consider."[59]

In essence, the Buck Report shuffled the VON out of public health nursing in Winnipeg, and relegated it to the margins of the publicly funded health and welfare system. Disease prevention, through the establishment or strengthening of local health units, better access to diagnostic facilities and physicians, and the provision of hospitals in rural Manitoba became the mandate of the Department of Health and Public Welfare.[60] Responsibility for the provision of community-based bedside nursing care remained in the voluntary sector. The VON would have to wait until 1974 to re-enter Manitoba's publicly funded health care system when home care became a publicly insured program.[61]

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[57]VON, Manitoba Branch, Minutes of December 10, 1941, and January 14, 1942; Executive minutes of January 23, 1942.

[58]VON, Manitoba Branch Minutes of March 11, 1942.

[59]VON, Manitoba Branch, Board minutes February 11, 1942.

[60]AM, Minister of Health Papers, H-8-5-2. The Manitoba Health Plan.

[61]Shapiro, *Home Care*.

The Extension of Full-Time Public Health Programs to Rural Manitoba

In 1944, after two years of planning, Jackson moved the full implementation of the Buck Report one step further when he unveiled a plan to improve health care services in rural Manitoba. In a memo to Ivan Schultz dated July 12, 1944, Jackson weighed the risks of its implementation, and assured the Minister that the province could go it alone should the federal government decide against the national health insurance program recommended in the Heagerty Report. At the same time, he stated, the plan would not interfere with any subsequently introduced federal program.[62]

The Manitoba Health Plan, mandated under the Health Services Act, was formally announced in January 1945 as part of Manitoba's post war reconstruction plan.[63] By dividing rural Manitoba into health regions and specifying the services that would be provided by rural health units, it was intended to "improve the whole standard of medical care" for the rural citizens of Manitoba.[64] Two-thirds of the program's costs were to be provided out of provincial coffers, with the remaining funds contributed by participating municipalities. Each local region was expected to make its own decision as to whether or

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[62]AM, Minister of Health Papers, File H-8-5-2e. Memo from F.W. Jackson to Ivan Schultz dated July 12, 1944.

[63]"Schultz Submits $5,500,000 Plan", *Winnipeg Free Press*, March 25, 1944; "Provincial Health Plan", *Winnipeg Free Press*, Jan. 12, 1945; "Peace Projects Placed Before Manitoba House", *Toronto Globe and Mail*, Feb. 7, 1945.

[64]AM, Minister of Health Papers, File H-8-5-2. "Proposed Plan for Preventive Medical Services for Rural Manitoba, Showing Only Six Large Areas." Memo from C.E. Mather, Director, Local Health Services to F.W. Jackson, dated February 17, 1945. File H-8-5-2 contains various correspondence, memos, newspaper clippings and a copy of the Manitoba Health Plan, including addresses by Hon. Stuart Garson, Premier and Hon. Ivan Schultz, Minister of Health and Public Welfare.

not it would participate in the program. "For years," stated an information pamphlet directed to interested rural communities, "cities have had Departments of Health . . . NOW IT IS POSSIBLE FOR RURAL AREAS TO ENJOY A SIMILAR SERVICE [capital letters in original]."[65] Clearly anticipating an infusion of federal funding to support this initiative, Premier Garson acknowledged that "[T]o operate this plan will cost the provincial treasury, the municipalities of Manitoba and, we hope, the Dominion treasury, a good deal of money."[66]

Jackson's master plan consolidated total responsibility for the provision of all rural public health services in Manitoba within the Provincial Department of Health and Public Welfare, and placed the local administration of these programs in the hands medical health officers. Regional health units were to be headed by "medical men" with additional training in public health.[67] To obtain the cooperation of organized medicine, extensive consultations with the Manitoba Medical Association were undertaken.[68] Their general support of the plan, stated Ivan Schultz in a memo to Stuart Garson, was "due to the fact that we took them completely into our confidence and discussed every detail of

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[65]AM, Minister of Health Papers, File H-8.5.2a.

[66]AM, Minister of Health Papers, File H-8-5-2, *The Manitoba Health Plan*, 1.

[67]AM, Minister of Health Papers, File H-8-5-2. "Proposed Plan for Preventive Medical Services for Rural Manitoba, Showing Only Six Large Areas." Memo from C.E. Mather, Director, Local Health Services to F.W. Jackson, dated February 17, 1945.

[68]AM, Minister of Health Papers, File H-8-5-2. "Report to the Manitoba Medical Association by Committee on Economics Regarding Manitoba Health Scheme Proposed by the Minister of Health, 1945."

legislation with them . . . which is, of course, their right, and our own responsibility."[69]

Similar rights were not accorded to the nursing profession. Consultations with the Manitoba Association of Registered Nurses are not documented in the Minister of Health papers. Nursing's cooperation with the Manitoba Plan was either taken for granted or not deemed important enough to negotiate beforehand. Under the provisions of the Manitoba Plan, practising nurses were subordinated to physicians. Public health nurses, "the first and most important group . . . outside of the medical director," would perform "the bulk of the routine work" under the health officer's direction.[70] The fact that, since 1916, provincial public health nurses had laboured under difficult circumstances, often in complete isolation from other health care professionals, to bring rudimentary public health programs to the citizens of rural Manitoba was never acknowledged, nor were the skills and experience of these nurses deemed valuable enough to merit their participation in planning to reorganize public health services in Manitoba.

Similarly, lay women were relegated to token participation in efforts to strengthen health care services at the local level. The decades of voluntary efforts by groups such as the Women's Institute, the United Farm Women of Manitoba, church missionary societies, and the Local Council of Women to improve the health care of rural

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[69]AM, Minister of Health Papers, File H-8-5-2. Memo dated June 14, 1943. It is attached to a letter from Dr. Roy Martin, dated June 4, 1945 to Ivan Schultz assuring him that the MMA are "100% behind you in this enterprise." Schultz, in his memo to Garson, states that "perhaps Dr. Martin exaggerates the extent of the favorable reaction, but it is quite true that the doctors have show an increasing amount of co-operation."

[70]AM, Minister of Health Papers, File H-8-5-2. "Health and Welfare Activities, 1944." Address delivered in the Manitoba Legislature on the occasion of the introduction of Estimates, March 6, 1945.

Manitobans received no mention in official government documents.[71] Although presentations were made to these groups at their request, both government officials and the women themselves evidently treated these as information sessions rather than as formal consultations. For example, the Women's Institute wrote a letter thanking Ivan Schultz for a "very interesting and instructive address" given at their convention and expressed the women's gratitude for his "taking the time to come to speak to them."[72] However, further discussions were not requested by either party. Even more revealing is a government pamphlet "Health Services for *Your* Community: A Plan for Happier Future." A photograph captioned "The Community Talks it Over" shows five men and two women (in hats) seated at a table.[73] Although authored by a female bureaucrat, Margaret Nix, the pamphlet both establishes and confirms the dominant role accorded to men in all aspects of the implementation of the Manitoba Health Plan. There was little room for lay women and limited autonomy for professional nurses in the "happier future" promised by Manitoba's publicly funded health care system.

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[71]For a description of Manitoba women's voluntary work in the area of health and social welfare, see: Kinnear, *A Female Economy*, 138-155; Taylor, *Fashioning Farmers*, 112-115.

[72]AM, Minister of Health Papers. File H-8-5-2. Letter from Marion McKenzie, Corresponding Secretary of the Women's Institute to Ivan Schultz dated June 8, 1945.

[73]AM, Minister of Health Papers. File H-8-5-2a.

Conclusion

This chapter considered the impact of the emergent Canadian welfare state on voluntary female-led health care agencies in Winnipeg, on the autonomy of public health nurses employed by health departments, and on the ability of women to participate fully in the planning and implementation of publicly funded public health programs developed in the early 1940s. On balance, the analysis of events in Winnipeg and in rural Manitoba demonstrates that women were increasingly excluded from active participation in the design of public health programs which, ironically, emphasized the health of women and children. Public health nurses, although now supervised by members of their own professional group rather than lay males, enjoyed only limited autonomy within the public health system. Their practice was overseen by medical health officers, who were identified as the key players in the successful implementation of the Buck Report and the Manitoba Health Plan.

The outcome for female-led voluntary health care agencies was equally disappointing. In the same way that patriarchal relations reshaped the fiscal structures of the Scott Mission and the VON, and forced both organizations to serve the needs of the medical profession, patriarchy also significantly altered the destiny of these organizations during the post war reconstruction planning in Manitoba. Neither organization merited a place in Manitoba's publicly funded health care system. The VON's limited mandate as the provider of uninsured and charitable visiting nursing services in Winnipeg created an uncertain future for the organization. With only limited access to government grants, its Board was left to shoulder the challenging task of obtaining funding to provide this

service from other sources. The Mission, having long outlived its philanthropic origins, discontinued its visiting nursing program and instituted a search for "other charitable work for which there might be a need in the Community."[74] Within the year, hampered by an aging membership and limited financial resources, it disbanded and sold its remaining assets.[75] With the integration of school health and maternal/infant programs into the city health department, and the transfer of charitable bedside nursing to the city's welfare system, the face of Winnipeg's public health system had been profoundly transformed. Female-led visiting nursing associations had lost their both their leadership role and their autonomy in the new publicly funded system.

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[74]AM, The Mission papers, MG 10, B9, Box I, Correspondence. Letter dated September 19, 1941 from Mary Burbidge, Secretary of the Mission. The letter is an invitation to a General Meeting to be held October 3, 1941 to consider the recommendations of the Special Committee struck by the Mission Board to discuss the recommendations of the Buck Report.

[75]Macvicar, *Margaret Scott*, 26.

Chapter 9

Conclusion

A study of women's contributions to public health can reveal much about twentieth century Canadian society. Despite the fact that a great deal has been written about the history of public health in Britain, the United States, and to a lesser extent Canada, this thesis demonstrates that there is still space for local studies which explicitly examine the largely unacknowledged contributions of lay and professional women. This approach facilitates the integration of aspects of public health's story which are, to date, often found in separate bodies of literature. Men's contributions to public health, for example, are most frequently found in traditional accounts of the discipline's development; public health nurses' experiences are often little known outside of the history of nursing; public health's impact on clients is most frequently discussed in the histories of women and moral regulation; the story of elite female reformers is generally found in studies focussed on maternal feminism, the rise of professional social work, and the emergence of the welfare state. As this study demonstrates, the integration of the seemingly parallel and disconnected efforts of male sanitarians and female social reformers results in a synthesis of existing scholarship in these fields that clarifies the development of health policy and traces the influence that the ideology of gender had in shaping roles for men and women in the public sphere. Two additional observations need to be made at this point. The first is that synthesis requires an existing body of literature from which to draw both inspiration and interpretations. The work of other historians, therefore, is the foundation upon which this analysis rests. The second is that the complex

nature of public health makes attempts at synthesis a daunting task. Certainly, more scholarship in this area is needed, and this local study cannot be regarded as the final word on the themes it articulates.

This thesis argues that gender shaped the roles available to both men and women in Winnipeg's public health system. In the late nineteenth and early twentieth century, Winnipeg's civic public health department, under the leadership of A.J. Douglas, focussed almost exclusively on the masculine enterprises of sanitation and regulation. The establishment of a modern water and sewage system, the elimination of private wells and privies, housing inspections, and the inspection of the city's food supply were all incorporated within the city's health department by early 1900. This approach to public health, however, had its limits. Analysis of the department's campaign to regulate the city's milk supply reveals that a combination of contentious scientific findings and competing professional agendas absorbed an enormous amount of energy and sidetracked city health officials into a dairy policy which did not fully protect the public's health. Separating the dairy industry into tuberculin and non-tuberculin tested herds, and requiring that only milk from non-tested herds be pasteurized prior to sale still left the public vulnerable to milk-borne outbreaks of typhoid fever and scarlet fever. Further, there is little compelling evidence that the health department's focus on the eradication of tuberculosis from the milk supply through tuberculin testing was scientifically correct or that regulation of the dairy industry was the most effective approach to the control of tuberculosis in the community. In the end, economics and politics won the day. The repercussions of the contentious debate about who should bear the cost for a

comprehensive bovine tuberculosis eradication program were felt long after the protracted debates of 1894 - 1922. Winnipeg did not pass a by-law requiring that all milk offered for sale in the city be pasteurized until 1982.[1]

In the late nineteenth and early twentieth century, the public roles available to middle class and elite women were also shaped by gender. The domestic ideal, which gave women moral authority in the home, also gave them the opportunity to work in the public sphere when their work could be conceptualized as a "natural" extension of their domestic duties. Throughout this era, friendly visiting in the homes of the poor was an accepted expression of female piety and charity. However, more organized programs soon overtook this highly individualistic and uncoordinated approach to social reform. Women became involved in the settlement movement and other organizations dedicated to improving the lot of "the less fortunate." As white females ministering to ethnic and racial "others" in their own communities, elite and middle class married women were able to approximate the autonomy and social power enjoyed by unmarried female missionaries working in the mission fields both at home and abroad. In addition to finding work which satisfied their need to participate in the wider social reform movement of the late nineteenth and early twentieth century, these women also found great personal satisfaction in alleviating the suffering of the sick poor. Capitalizing on the legitimacy bestowed on this work by gendered notions of ideal womanhood and the intimate connection between charity and faith, female social reformers ultimately attained leadership roles in local and national charitable organizations. However, as historians

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[1]CWA, Council Minutes, July 14, 1982.

have observed in their analysis of the professionalization of social work, lay women's control of organized charity was eventually undermined. As charitable organizations became more administratively complex and more dependent on external funding, female social reformers gradually lost meaningful control of the organizations they had founded.

Much the same story unfolded in Winnipeg. Between 1897 and 1904, the city's district nurse was funded by the Winnipeg General Hospital, philanthropic businessmen, and the City of Winnipeg Health Department. However, in 1904, control of charitable visiting nursing was placed in the hands of the all-female Board of Management of the Margaret Scott Nursing Mission. In 1905, the Winnipeg Branch of the VON inaugurated their visiting nursing service, and the Women's Anti-Tuberculosis Society hired a visiting nurse, Annie Rathbone, to provide nursing care to tuberculosis patients and their families.[2] The nearly simultaneous formation of these three visiting nursing organizations marked an important milestone in the history of public health in Winnipeg. Women were deemed capable of both organizing and providing direct nursing care and health education programs in the community. For the entire period under study, the Boards of both the Mission and the VON were exclusively female. Although both organizations also established all-male Advisory Boards, men's input was only sought when decisions

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[2]Mitchell, "Life Piled on Life." A copy of this speech is found in the Archives of Manitoba. See: Minister of Health Papers, 1932-1952, Gr1551, G1262, H0001, Aisle G, Bay 12, Shelf 92. In his speech, Mitchell states that the Society was founded "about" 1905. In his annual report of 1909, A.J. Douglas, Winnipeg's Medical Health Officer, states that an active anti-tuberculosis society was founded in 1908 by group of physicians who had attended the Washington Tuberculosis Congress earlier that year. It is difficult to determine whether this was the same, or two different groups. See: CWA, Department of Health, *Annual Report* (1909), 6.

involving the acquisition of real estate or the expenditure of large sums of money were under consideration. Day-to-day decisions about the work of each organization, the supervision of its employees, and the sources of revenue secured to sustain their activities were retained by women.

In her analysis of the 1918-19 influenza outbreak in Winnipeg, Esyllt Jones argues that the health department's focus on quarantine, immunization, and public education, and its decision to leave responsibility for the physical and emotional care to the voluntary sector was a serious weakness in the city's response to the plight of its working class citizens.[3] This thesis confirms and extends Jones's findings. The gendered division of public health services between civic regulation and voluntary caring, so problematic during one of the city's worst public health crises, had actually been established fourteen years earlier when the Margaret Scott Nursing Mission was founded in the midst of Winnipeg's worst typhoid epidemic to provide nursing care in the homes of the "sick poor."

Providing public health services on a voluntary basis, however, is a daunting undertaking. As Winnipeg's women were soon to discover, putting their visiting nursing agencies on a secure financial footing and maintaining meaningful control of their operations was a difficult proposition. The VON's participation in the Federated Budget scheme severely constrained the autonomy of their Board and, when grants from this source failed to match those the Board had previously obtained through their own fundraising efforts, the financial shortfall nearly bankrupted the organization. The

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[3]Jones, "Searching for the Springs of Health," 275.

Mission's continued dependence on the philanthropic support of interested individuals was equally perilous. With each successive decade, charitable donations decreased, and the needs of the Mission's patients continued unabated. As a result of the failure of charitable support, both the VON and the Mission became heavily dependent on government grants to maintain their services. Although this strategy stabilized their financial situations, it also made them unofficial components of the civic and provincial health departments. This development destabilized the previously established division of labour between men and women in the public health system and narrowed the scope of women's control over the public health programs that they had founded.

As greater political interest in the creation of a publicly funded health care system developed, the charitable nature of the services provided by Winnipeg's visiting nursing agencies became politically and socially unacceptable. Indeed, it was likely that the women who organized Winnipeg's first visiting and public health nursing services also believed that the state was responsible to ensure that these services were provided in the community. It is even possible that at least some members of the Boards of the Mission and the VON were more than happy to be relieved of the financial headaches engendered by their dependence on charity and government grants. However, it is less likely that they anticipated or welcomed their virtual exclusion from further policy development or any other form of meaningful participation in Winnipeg's public health system. As other historians of the welfare state have observed, female reformers who linked their social and political platforms with male political actors rarely retained control of the agenda and often found themselves relegated to the sidelines when government sponsored programs

were implemented.[4] Like the female workforce that had made such a significant contribution to the nation's war effort between 1939 and 1945, Winnipeg's female social reformers were also subjected to patriarchal divisions of labour in the post war period.[5] They were asked to step aside to make way for the men who took leadership roles in the restructuring of Manitoba's public health system and the development of the welfare state. Public health, firmly in the grasp of male bureaucrats and professionals, contained little space for the ideas, energy, or opinions of lay women.

This thesis confirms that the women who pioneered public health programs in the voluntary sector have been overlooked in the historic record. This is certainly the case for the women who established school health, child health, maternal health, and occupational health programs in Winnipeg. Once these programs were incorporated into the publicly funded system, the contributions that female reformers and visiting nurses had made to their development were virtually forgotten.

Other studies have observed that visiting and public health nurses lost professional autonomy within an increasingly medicalized and bureaucratic health care system.[6] This thesis provides further insights into the process by which nursing lost control over its practice. It argues that gender conferred upon organized medicine the professional and political authority which enabled it to reshape nursing's practice in the community and bring it under the control of physicians. At the beginning of the twentieth

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[4]Koven and Michel, "Womanly Duties."

[5]Pierson, *They're Still Women After All.*

[6]Buhler-Wilerson, *False Dawn*; Stuart, "Let Not the People Perish".

century, when organized medicine had significantly less to offer in terms of effective treatment of the sick, and when civic health departments had only a limited interest in the contributions that nurses could make to their enterprises, visiting nurses, particularly those who ministered to the poor, enjoyed considerable autonomy in their work. However, in Winnipeg, this state of affairs quickly changed when the VON began to provide care to paying patients. Perceiving this type of nursing practice as a potential threat to their incomes, physicians in Winnipeg mobilized to ensure that these nurses worked only under their supervision and followed policies and procedures which had received their prior approval. The female-led local Board and the national nursing supervisors were quick to endorse these arrangements because the VON's continued survival depended upon a cordial working relationship with practising physicians. The Mission's nurses enjoyed considerable autonomy in the delivery of that agency's child hygiene program, but when these same nurses were transferred to the city health department in 1914, they were placed under the supervision of a lay male bureaucrat. Civic public health nurses were not supervised by a member of their own profession until 1945. Even after that date, ultimate authority over the nature and scope of their work rested in the hands of the medical health officer and male civic bureaucrats.

Also confirmed in this study is the reality that public health programs serve the interests of the state as well as the needs of the people. Public health's least discussed goal may well be the maintenance of social order and the regulation of individual behaviour. The Mission's participation in the moral regulation of immigrant women and children reveals that the material and physical care provided to the "less fortunate," and

the health education programs deployed in public schools were a convenient vehicle for the dissemination of multiple messages about the appropriate behaviour, attitudes, and beliefs expected of Canadian citizens.

In the course of this study, many questions have been addressed. The increased interest which both organized medicine and the state took in protecting the health of infants, children, and mothers, for example, explains why the voluntary programs founded by women to protect the health of these populations were eventually medicalized and integrated into civic and provincial public health departments. However, many other important questions remain unanswered. Why, for example, were the bedside nursing services provided by the Mission and the VON not transferred to the publicly funded health care system during 1941 -1945 post-war planning discussions? And why were similar services not established in rural Manitoba? Certainly, F. W. Jackson's initial proposal for the establishment of a health program for rural Manitoba included the employment of visiting nurses to provide bedside nursing services.[7] Other questions also emerged. If public health's mandate includes "all the people," why were there no preventive health services established to meet the unique health concerns of men or seniors? Clearly, female social reformers' primary concern for the health of women and children established a legacy and a pattern which shaped the publicly funded health care system far more profoundly than existing histories of the discipline have acknowledged or perhaps even realized.

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[7]AM, Minister of Health Papers, GR1551, G1262, H0001, file H-8-5-2e, memo from F.W. Jackson dated June 16, 1944 titled "Summary of Proposals for Health Programme in Rural Manitoba.

Finally, the story of the development of Winnipeg's public health system reveals that the welfare state, for all its benefits and advantages, privileges some segments of society and marginalizes others. At its best, a publicly funded system removes from its citizens the humiliation of seeking charity when personal need outstrips personal financial resources. At its worst, the welfare state is patriarchal, rigid, and unwilling to seek outside advice. In the development of Winnipeg's public health system, both voluntary and civic, immigrant women and children were the objects of seemingly well-intentioned interventions to both preserve their health and refashion them as "model" Canadian citizens. Their opinions on the form and substance of Winnipeg's public health system were apparently never seriously considered. Although women initially participated in and even initiated public health programs, changing ideas about the scope and nature of their roles in the public sector eroded the ideological basis of their work and narrowed the scope of their influence. At the turn of the twentieth century, gender had created a space for lay and professional women to provide direct public health services to Winnipeg's women and children. By mid-century, organized medicine and the emerging welfare state had successfully contested their right to provide these services on their own terms and in their own way. In the massive reorganization of Manitoba's health care system between 1941 and 1945, the Margaret Scott Nursing Mission closed and only non-publicly insured visiting nursing services were retained by the VON. All other public health programs previously offered by these two female-led agencies were transferred to the appropriate local health department. Thus, by the end of the Second World War, policy development in Winnipeg's public health system was a masculine enterprise.

Appendix 1

Extract from the *Manitoba Free Press* Report of November 12, 1904 Organizational Meeting of the Margaret Scott Nursing Mission

A largely attended meeting of ladies and gentlemen interested in the "Margaret Scott Nursing-at-home Mission" was held in the Y.M.C.A. rooms on Saturday. Dr. Jones was appointed chairman and Mr. G. D. Minty secretary on the motion of ex-Ald. Barclay. The chairman thought it unnecessary to outline the objects of the movement, as these had been thoroughly discussed at a previous meeting: and as the present one was for organization. He invited any who had not joined, to become members, and number responded, giving their names and membership fees to Mrs. Minty.

The Object

The secretary read a paper written by Miss Isabella M. Stewart, a nurse graduate of the Winnipeg general hospital, who has had some experience in at-home nursing, as follows, showing what the society is and what it has to grapple with.

It does seem presumptuous for one who has really seen such a short service in this kind of work to try to tell you about district nursing as it is in Winnipeg. But as is usually the case, those who do the work can never be persuaded to speak of what they have accomplished. I feel assured that if you were to ask Miss Scott and Miss Lamonte to give you an account of what they are doing among the poor of Winnipeg you would get a very unsatisfactory report, so perhaps an outsider who has had a little glimpse of the inside view of the work may be able to speak of it impersonally and consequently with more freedom.

The district nurse in Winnipeg is, as you know, under civic jurisdiction and is expected to cooperate with Dr. Douglas and the board of health in relieving suffering and distress, in preventing the spread of infectious and contagious diseases, in promoting good hygienic conditions in the poorer and more crowded quarters of the city. Working in conjunction as she does with the City Missionary and other philanthropic workers, she seeks also to elevate their standard of living, morally as well as physically. The patients come to her notice through the city doctors, who have long since realized the value of a trained nurse's visits to their poorer patients: through district visitors, and very often through friends who have perhaps benefited themselves from her former ministrations.

If a doctor has not been consulted and the case demands his attention, the nurse reports to the family doctor or whatever medical advisor they may choose; but if they are unable to pay the city doctor attends them free.

If at all possible the patient is advised to go to the hospital and arrangements are made by the nurse, but often this is impracticable, either from the crowded condition of our hospitals or from the nature or environment of the case. A sick mother, for example, often finds it impossible to dispose of her children, or afford them proper care in her absence and if the wage-earner has to come home to keep the house there is nothing to live on. The aged, too weak and frail and often indisposed cannot easily be torn away from their homes. they do not thrive in new and strange surroundings, and the system and

cleanliness of the hospital regime are poor compensations for the familiar face of husband or wife and the freedom of one's own chimney corner. The nurse looks in often on her round, sometimes urges a little tidying-up, and sees that the washing is sent out; if necessary reports to the city relief officer of the church they belong to, and arranges for rent and food and warmer clothing. If illness comes, she is able to see that the patients is kept comfortable and clean and the doctor's treatment is carried out.

Then there are the long chronic cases of rheumatism, Bright's disease and consumption. The patient is up and down and needs only an occasional visit or if confined to bed for years there is usually arrangement made for some kind of constant attention. But this is often unskilled and the helper is glad to welcome and adopt the instructions and suggestions of the visiting nurse as to bathing, moving, changing of linen, prevention of bed-sores, and the many little contrivances that make such a difference in the comfort of the bed-ridden invalid. Unless tubercular patients can be treated by the open-air method in sanitariums, they are as well in their own homes as anywhere. But they must have air and sun and good food and proper clothing and the danger of contagion eliminated as far as possible by proper disinfection. This is the nurse's work, that by constant visiting, ceaseless teaching and strictest vigilance, the patient himself may be enabled to fight the chance for ultimate recovery and the health of the family and of the community safe-guarded.

The same precautionary measures must be taught in nursing typhoid, dysentery or cholera morbus in private homes. The excretions must be carefully disinfected, the breeding places of infection discovered and radical measures enforced to prevent its further spread. How much of the rate of infant mortality might be lowered in the hot summers if mothers could only be taught the proper methods of feeding, the simple rules for the sterilization of milk and a few principles of plain hygiene!

Obstetrical Work monopolizes a large share of Miss Lamonte's time and perhaps this is one of the most important branches of district nursing. That is, to visit the expectant mother and advise her in the proper care of her health, to assist the doctor during her confinement and to attend to mother and babe daily for the regulation period of lying-in. Often it is necessary to provide linen for the bed, clothing for the infant and to see that the little family has food and some supervision as to cleanliness and proper clothing. They do manage, strange to say, the husband doing his best (sometimes) night and morning while the children fetch and carry, keep on fires and run messages, and the mother, usually with two or three of the younger ones in bed with her, tries to keep things running. One little women, whose oldest child is a boy of 8, depends on him for housekeeping, cooking and nursing while she is in bed for her week or ten days. Many are obliged to rise themselves to attend to fires and food or little ones would perish. Here again the nurse's assistance is often solicited too late, when neglect and ignorance and uncleanliness have done their work and then a long battle has to be fought out, with puerpuval [sic] fever. If indeed the life of the mother can be saved at all.

At the coffee house, too, where the district nurse has had her headquarters, there are always sore throats, heads and hands and feet to dress and often very sick men to be sent to the hospital. These are usually single men, far from home and friends, and from their

own or some one else's fault, usually at the lowest extremity, financially, yes, and morally.

The people with whom one comes in contact in the district work are all, however, not of the lowest and most degraded. Many new to the country are putting in their preliminary hard time, have had bad luck, illness, loss of work and are stranded for the time being. They need to be helped, encouraged and tided past their time of distress. Others, wives and children, suffer through a lazy, incompetent, drunken or sick husband or father. Here the co-operation of Children's home, Woman's home, the Salvation Army or the Children's Aid society does much to afford relief where it is impossible to keep home and family together. Foreigners coming to the country are often in the most miserable poverty and very poorly equipped to battle with our rigorous climate and new social conditions. Crowded into cold, damp, unhealthy houses, with little or not fuel, with poor food, bad air, and insufficient clothing, is it small wonder that disease breeds among them. These people must be taught how to live.

As to results, it is hardly necessary for me to speak. the patients themselves will tell you how much has been done for them, in nursing their sick, in relieving their wants, in encouraging them and brightening their lives; district nurses will tell you of improved conditions in home - practical evidences of Miss Clark's Miss Rathbones' or Miss Lamonte's good influence and interest, and the city doctors will cheerfully testify to the many well-fought conflicts with typhoid and pneumonic and even of surgical cases, which would have beyond their skill to help had the nurse not come in to give her assistance, her instructions and encouragement to the worn wife or daughter or mother, who was doing a poor best to carry out his orders. Miss Lamonte has found in the poor homes some very apt and intelligent amateur nurses, who quickly copy her methods, faithfully follow instructions, and take a great delight in meriting her approval.

It is surely unnecessary to say that one nurse for the poor of a city whose whole population numbers from sixty to seventy thousand is whlly [sic] inadequate. In other cities four to six visits a day are considered work for one district nurse and her day begins at 8 a.m. and ends at 6 p.m. Miss Lamonte averages from six to ten visits in a day. She works all day, and in the busy season, all evening: she is called out at any time during the night and sometimes is out all night. Her work is over the whole city and she covers the distance by car, by wheel, but often on foot. What human effort could do, she has done, but it is useless to even imagine that strength even such as her's can be expended so lavishly without disastrous results. And the field for work has widened so much that even with this help in the busy seasons the forces are quite inadequate.

In organizing some definite means for carrying on this district work, you will also be able to lend some assistance to that other faithful and courageous worker to whose effort and inspiration the nursing work as we have it is largely due. You know her work and her worth - you have seen how unstintingly she is spending her life, in the interests of the poor, the unfortunate, the unreclaimed - yes, and the vicious of the city. Surely no effort should be too great that would help to spare this good women for the work in which she has already accomplished so much, and for which she is sill so much needed.

Mrs. Minty's Letter

Mrs. Minty, secretary pro tem. presented a report, stating that the society had been inaugurated by a few ladies at the instance of Mrs. Scott, city missionary, the burden of the work having become too serious a problem for her and the district nurse, Miss Lamonte, so that a home became necessary. A committee was appointed to form deputations to approach the city councils and the city and Dominion governments; and it was decided to be advisable to hold a public organization meeting to arouse interest in the movement. This meeting was held in May last and was well attended showing the citizens to be in sympathy with its objects. Voluntary subscriptions were received; and the outcome of the deputation to the mayor was a promise of $2000 towards inaugurating the work and a yearly income of $1200. Delay occurred owing to Mrs. Scott's absence from the city; and the two nurses had a very trying experience demonstrating the need of an organization. Reference was here made to the paper of Miss Isabella M. Scott [sic], who spoke from actual experience, also to Mrs. Scott as a good Samaritan, a ministering angel to the poor, the nature of whose noble work words cannot express.

Mrs. Scott thanked all for the honor conferred upon her in giving her name to the home. She felt she owed a debt of gratitude to her Heavenly Father for raising up so many friends to give their time and funds to the work. She trusted the work would be carried on in the same spirit, the spirit of Christ who taught us to bear one another's burdens.

Resolutions

Several resolutions were then passed as a basis of a constitution: the first declaring the objects of the society to be formed under the benevolent Society's act, namely, nursing the sick poor in their own homes, establishing a depot or depots for residence of district nurses, the securing of land and building, staff of nurses and assistants, etc.: the second adopting the name, "Margaret Scott Nursing-at-home-mission," as an acknowledgment of Mrs. Scott's self-sacrificing labors. The first of these was moved by ex-Ald. Barclay, and the second by Rev. Dr. DuVal, who spoke of Mrs. Scott as having been made a channel through which God has sent healing, comfort, blessedness and uplift in an untold number of ways. "We honor ourselves" said the speaker, "more than we honor her." Other resolutions provided that membership shall be open to all on payment of an annual subscription fee of one dollar: for life members and honorary members: for a board of directors composed of an advisory board of ten gentlemen and a board of management of twenty-five ladies, each having power to add to its numbers: the officers to be a president, three vice-presidents, secretary, treasurer and solicitor.

The members of these two boards were elected as follows:

Advisory board - Mr. W. F. Alloway, Mr. A. M. Nanton, Mr. G. F. Stephens, Dr. Blanchard, Dr. Jones, Dr. Douglas, Mr. Thos. Robinson, Captain Robinson, Mr. H. H. Smith and the mayor.

Board of management - Mrs. Scott, Mrs. E. H. Taylor, Mrs. J. T. Gordon, Mrs. E. M. Wood, Mrs. Colin Campbell, Mrs. Wm. Robinson, Mrs. G. D. Minty, Mrs. Higginson, Mrs. Moody, Mrs. Fred Morse, Mrs. Todd, Mrs. Sugden, Mrs. Oldfield, Mrs. Brough, Mrs. F. J. Sharpe, Mrs. Daly, Miss Drummond, Mrs. Stidston, Mrs. Haggart, Mrs. Geo.

Murray, Mrs. Fares, Mrs. Ashdown, Mrs. David Fleming, Miss Brunstermann and Mrs. D. C. Cameron.

Further resolutions directed that at as early a date as possible deputations shall approach the provincial and Dominion governments and submit the claims of the society to their consideration.

Votes of thanks were passed on motion of Messrs. Barclay and Thos. Robinson, to the chairman and secretary and Mrs. Minty.

The meeting adjourned to the same place and hour two weeks from date to receive the directors' report on organization.

Those present at the meeting were: madames Lady Schultz, E. H. Taylor, Stuart Tupper, W. J. Tupper, F. Phillips, Bull, Mackenzie, W. J. Anderson, E. M. Wood, Brough, Higginson, Parker, Richardson, Waddington, Clark, Moody, Fortin, Fowler, F. Sharpe, Harris, R. D. Richardson, G. R. Crowe, W. J. Anderson, Mrs. Fred Morse, Mrs. Pepler, Mrs. A. S. Mackenzie, Miss Drummond, Miss Brunstermann. Messrs. Thos. Robinson, W. F. Alloway, D. C. Cameron, Rev. Dr. DuVal, Rev. Chas McKim, ex-Ald Barclay, J. W. Harris, Dr. Moody and R. D. Richardson.

Appendix 2

Methodology for Chapter 6: Public Health's Other Agenda: The Moral Regulation of Immigrant Women and Children by the Margaret Scott Nursing Mission

Evidence to support the argument that the Margaret Scott Nursing Mission operated as an agent of moral regulation was drawn from both primary and secondary sources. The most important primary source was the Margaret Scott Nursing Mission Papers located at the Provincial Archives of Manitoba. The papers are grouped into two general categories. Publicly accessible documents related to the operations of the Board of Management and its committees are located in Boxes I - VI of the collection. Restricted access documents containing demographic and medical information about individuals and families visited by the Margaret Scott Nursing Mission Nurses and Board of Management Members between 1908 and 1921 are located in Boxes VII-X.

A variety of primary and secondary sources, including those found in the Mission's papers, were used to identify members of Board of Management and to construct a description of their social and demographic characteristics. All members of the Board between 1904 and 1921 were included, resulting in a sample size of seventy-four individuals.

A description of the cultural, religious, and economic attributes of the Mission's clients were obtained from the Applications for Nursing Attendance and Relief [hereafter, 'Applications']. Access to these records was obtained from the Provincial Archivist on the condition that the anonymity of individuals identified in these records be maintained at all times. The records consist of a total of approximately 11,000 Applications

documented by the Mission between August 1908 and December 1921. The exact number of cases is not known. Individual applications are bound into eight large looseleaf binders which are clearly labelled by date and, where necessary month, of the applications they contain. The Applications are numbered sequentially, beginning at 1, but some are missing for each year. Although not specifically verified, the years 1908 and 1921 appear to have the most instances of missing records. In the case of 1908, the records are simply not there. In the case of 1921, there is evidence that records have been torn from the casebook.[1] Each Application is a one page record of basic demographic and medical information regarding the applicant and his/her family. A reproduction of the Application form is included at the end of the Appendix.

The information documented on these Applications was analysed for two purposes. The first was to assemble a general description of the characteristics of the patients served by the Mission.[2] Initially, every fifth year (1908, 1913, 1918) was selected for analysis. Every fifth case in 1908 (because the Applications were implemented half way through the year) and every tenth case in 1913 and 1918 was sampled. However, to enable direct comparison of the sample's demographic characteristics with Artibise's

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[1]Kealey, "Filing and Defiling," 88-105. Kealy states that systematic and non-systematic gaps in documentary evidence pose threats to the validity of statistical tests conducted in the analysis of case records.

[2]Sager, "Employment Contracts in Merchant Shipping, 60. Sager argues that before the historian can identify "an exceptional or oppositional case", the threat to validity posed by selection bias must be addressed. Sager recommends that a representative sample of randomly selected cases be analysed to identify significant variables and trends imbedded in the data.

work, the years 1911 and 1916 were added.[3] A total of 315 cases were assembled using this procedure. An analysis of the characteristics of the sample facilitated the comparison of the Mission's patients and Board of Management members. Further, it enabled the identification of both typical and unusual patient situations to support the analysis of the Mission's role in social and moral regulation.

Elite attitudes towards Winnipeg's immigrant and working classes were discerned from the Mission's minutes, correspondence and annual reports, the testimony of student nurses, newspaper clippings, and the writings of influential Winnipegers including C. W. Gordon (Ralph Connor). Finally, evidence of the integration of the Mission into the wider moral regulatory project of Winnipeg's elite were drawn from the Mission's Board of Management minutes and Applications, and newspaper accounts of the Mission's work.

There are several challenges to valid interpretation of the evidence posed by the documents examined during the preparation of this paper. The first, and most important, is that the documents consulted were all written by supporters and employees of the Mission. The perspectives of those the Mission served are only occasionally found in these records. Within the Minutes and Annual Reports of the Board of Management, the grateful thanks of the Mission's patients are duly documented.[4] More difficult to identify

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[3]Artibise, *Winnipeg: A Social History*.

[4]The minutes of December 11, 1922 provide one example of a family's gratitude for the Mission's assistance. "Mrs. Scott said Mr. H. Simpson of 311 Bowman Ave. Elmwood took off the screens & put on the double windows of the Home free of charge & suggested that a letter be written to him. ... Mrs. Scott explained that a child of Mr. Simpson's had been very ill & nursed by Miss Clark some years ago & Mr. Simpson had deeply appreciated the nurse's work." AM, The Mission papers, MG 10 B9, Box IV, Board of Management 1904-1928.

is evidence that some clients resisted the services offered by the Mission and did not agree with the advice that they were given.[5]

Another challenge to valid interpretation is the illegibility of the handwritten minutes and Applications. Each change of Board secretary necessitated a renewed focus on deciphering handwriting and interpreting idiosyncratic abbreviations. Change and controversy, those "discontinuities" so eagerly sought by historians, were regularly accompanied by the worst examples of penmanship.[6] What does one make, for example, of the cryptic notation at the bottom of a client file that the patient was suffering from "an [illegible] abortion"?[7] Historians interested in the moral dimensions of district visiting could do much more with this notation if only the adjective could also be interpreted.

The Applications were first developed in June, 1908, in response to concerns expressed by the City of Winnipeg Board of Control that firm measures had to be taken to ensure that the services of Winnipeg charitable organizations were not provided to

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[5]AM, The Mission papers, MG 10 B9, Boxes VI - X, Applications for Nursing Attendance and Relief. In one case, the parents of a 2 ½ year old child who was being treated for burned hands called in another doctor and were reported as not wishing the nurses' treatment (Case 6502). In another case, a very ill woman was advised to go to the hospital by the attending physician, but the husband did not agree with this advice (Case 7888). A similar situation was reported in another case where the patient refused to go to hospital against the attending physicians' advice. (Case 10354)

[6]Joan W. Scott, "After History?" History and the Limits of Interpretation: A Symposium. Feb. 20, 1986. This source was obtained from a website, so the article has no page numbers. Her discussion about discontinuity is found under heading III: Is there history after the 'end of history'?.

[7]AM, The Mission papers, MG 10 B9 Boxes VI - X, Applications for Nursing Attendance and Relief, Case 6098.

"undeserving cases."[8] According to the Minutes of June, 1908 "Mrs. Scott [was to have] suitable forms printed that could be filled in with particulars of the charitable cases and forwarded monthly to the Board of Control."[9] Their main purpose, therefore, was to serve as a financial means test. Much more space on the form is devoted to the gathering of information regarding nationality, religion, type of employment, salary and housing arrangements than is provided for documentation of the medical problem and the nature of the nursing care provided. An additional challenge to validity emerged when it was determined that the forms were at least partially completed during a home visit, often in pencil, and sometimes by individuals whose handwriting could be barely deciphered. In this regard, Nurse Lillie Brown will be affectionately remembered for providing this historian with the most challenging examples of penmanship and spelling offered by the Mission's nurses. The particulars of many families she visited remain shrouded in obscurity. In sorting out the imperatives of physical need and accurate documentation, the nurses priorized nursing services over completion of the form.[10] Many potential inaccuracies and actual gaps in data result from this reality.

Interpretation of the financial status of the families was the most challenging

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[8]AM, The Mission papers, MG 10 B9, Box IV, Board of Management, 1904-1908. Minutes of June, 1908.

[9]AM, The Mission papers, MG 10 B9, Box IV, Board of Management, 1904-1908. Minutes of June, 1908. Why the Applications of 1908-1921 remained with the Mission, and whether those subsequently completed by the nurses were actually forwarded as planned is not known.

[10]One Application contained the notation by the visiting nurse: "Patient too ill to question further." Barely any information was recorded on the form. (Case 6784).

component of the quantitative analysis of the data found in the Applications. Wages were not documented consistently. Some were recorded as hourly wages, some as weekly wages and some as monthly wages. Conversion of all wages to annual incomes was calculated based on a 9 hour work day and a six day work week. These calculations, and the comparison of the resulting data to subsistence incomes were based on the work of Michael Piva and Terry Copp, who have conducted similar studies of working class incomes in Toronto and Montreal during the same time period as this study.[11] The mode (the most frequently reported wage) was chosen as the basis for comparison because it is less influenced by wide ranges in the data than are the median and the mean.

Last, interpretation of the data documented on the Applications must be approached with caution because many of the Mission's patients spoke little or no English. The degree to which this created a problem for the nurses is glossed over in the public records of the Mission. However, in the Applications, evidence of many threats to accurate demographic information because of language barriers can be discerned. One Application contains a notation by Eliza Beveridge that information was difficult to procure because the family spoke little English.[12] In addition, there many instances where the nurses clearly had difficulty spelling the family names of clients, the appearance of many names which bear little or no resemblance to those found in Winnipeg today, and the presence in the documents of at least two Mrs. Smiths of Eastern European extraction.

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[11]Copp, *The Anatomy of Poverty*; Piva, *The Condition of the Working Class*.

[12]AM, The Mission papers, MG 10 B9, Boxes VI - X, Applications for Nursing Attendance and Relief. Case 6553. Eliza Beveridge noted: "Unable to get complete history - very little English."

The statistical calculations derived from the data collected on both the Mission's Board members and its patients must be treated with caution. Analysis of incomplete and likely inaccurate data which was originally collected for an entirely different purpose can only be interpreted in the broadest of ways. Even so, the information obtained, particularly that on the Mission's patients, reveals a great deal about the cultural and economic characteristics of Winnipeg's wealthiest and most impoverished citizens, and confirms the deep chasm which existed between these two groups.

Margaret Scott Nursing Mission
Application for Nursing Assistance and Relief

Number:

Name: Age:

Address:

Nationality:

Church:

Sunday School:

Married or Single:

Names and Ages of Children:

Occupation, Man: Amount per week, $

Occupation, Woman: Amount per week, $

Nature and Duration of Illness:

Property Owned or Rent Payed:

Period of Residence in the City:

Period of Residence in Canada:

Relatives: Address:

How Assisted:

Number of Visits:

Doctor Attending:

Donations:

Remarks:

Signature of Investigating Nurse:

Approved by:

Date:

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Private Organizations:

Margaret Scott Nursing Mission Papers

Private Papers:

The Garson Papers

City of Winnipeg Archives

By-law Books
Board of Control Minutes and Communications to Board of Control
Council Minutes, Council Letter Register and Communications to Council
Health, Relief and Cemetery Minutes and Correspondence (1876-1883)
Market Committee Minutes (1876-1882)
Health and Relief Committee Minutes and Correspondence (1883-1886)
Market, Licence and Health Committee Minutes and Correspondence (1883-1908)
Health Committee Minutes and Correspondence (1909-1946)
Health Department Annual Reports
Health Bulletin
Pre-1920 Special Committees Files

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Biographical Vertical Files
Biographical Scrapbooks
Henderson Directory

Nurses Alumni Association Winnipeg General Hospital/Health Science Centre Archives

Blue and White
Winnipeg General Hospital *Annual Reports and Accounts*

Victorian Order of Nurses for Canada, Manitoba Branch

Board of Management Minutes
Annual Reports

University of Manitoba Archives

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