Acute Condition?
Exploring the Status of Corporate Archives in Canadian Hospitals

by

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ABSTRACT

In examining the status of corporate (or institutional, administrative or "business") archives in Canadian hospitals this thesis combines an exhaustive review of the literature with historical and anecdotal evidence and a formal survey of representative institutions. It discusses the types of institutional and administrative records and illustrates the choices that various institutions have made in collecting and preserving them. It pays special attention to the relationship between the archives and the corresponding records management program. Finally, it introduces the survey methods, such as the sample and questionnaire used, and the crucial issue of getting the questionnaire into the right hands. The results of the survey suggest a renewed case for such archives in light of current circumstances – since certain classes of holdings may well now be of greater legal significance or be preserved in vulnerable digital form – and their importance to the identity and social purpose of the hospital.

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INTRODUCTION

While the history of medicine is a well-established field, supported by a long-standing tradition of medical historiography, much less attention has been paid to the institutional records and archives that document the history of Canadian hospitals. Yet it is the hospital as an institution that occupies a central position in our lives and cities. As Charles Rosenberg argued in his monumental history, "The hospital is in some ways peculiarly characteristic of our society," and its historical development has "reproduced in microcosm the history of a larger society."[1]

It is the argument of this thesis that the corporate or administrative records of hospitals, though often overlooked and ignored, are in fact records whose value is both practical and historical. Their importance, in other words, lies not only in their relevance for reference and legal questions but that, beyond practicalities, they constitute an integral aspect of the institutional identity of hospitals and their position in the community.

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[1] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), pp. 3-4.

Tracing the history of corporate archives in Canadian hospitals against the background of the larger history of the hospital in Canada, this study explores the status of hospital archives and the way in which they have been viewed by archivists and archival scholars on the one hand and by hospital boards and administrators on the other. These historical reviews provide the background against which we examine the archival situation at three general hospitals in some more detail. With the stage set by these case studies, we develop the larger picture, on a national scale, of hospital archives in Canada by means of a more formal survey.

In general, the corporate archives of hospitals at a minimum hold records pertaining to the high-level running of the institution. In addition to board minutes and annual reports, these often include records documenting the relationship of the institution to the community of which it is a significant part, from the local and regional to the national and international. Another type of record prominently found in Canadian hospital archives concerns the establishment and development of the nursing staff, initially through Schools of Nursing run by the hospitals and now primarily in the domain of continuing education. The fundraising efforts leading to the founding and growth of both hospitals and nursing schools also provide a rich source of records, although they are typically scattered over a variety of repositories ranging from public archives to the private papers of the prime movers. Even the

newsletters and regular publicity materials issued by the institution and its constituent parts often provide interesting information for the historian, as do the records of the various volunteer guilds and alumnae/alumni groups; it seems particularly useful for a hospital archives to collect such ephemeral materials since they tend to disappear quickly in the normal course of events.

Diverse as they may be, all these corporate records are entirely distinct from patient records and medical records in the narrow sense. The sharp distinction found in the records themselves between medical or patient data, on the one hand, and administrative records, on the other, is crucial to defining the scope of the present thesis, which is limited to exploring the status of the administrative archives of Canadian hospitals.

The corporate records that lie at the heart of the present study also tend to be kept separate, though less sharply, from personnel files and legal records dealing with individual cases, and from fiscal records other than the strategic type, such as global budget plans. If the fundamental divide between the medical/patient records and the corporate records of the institution is made to appear less clearcut by, say, the existence of legal records, the best criterion for determining and documenting the key distinctions may be seen in the fact that the medical/patient records are typically well kept – and are subject to explicit legislative constraints (specifically the provincial

personal health information acts) – while the administrative records are not generally treated in the same way.

While the complex dialogue between the overall operation of the hospitals and the medical treatment and care they provide is a fascinating subject in its own right, the present thesis concentrates on one aspect of this intricate interrelationship that is essential though generally overlooked. The corporate archives provide evidence of the institution's efforts to instil a sense of pride, unity and common purpose in its staff, and this may well be the most important long-term benefit for the institution. The other fundamental argument for establishing and maintaining an institutional archives, and for implementing it in conjunction with a records management program, is the need to preserve a systematic and accessible collection of documents for future reference. The incalculable value that such archival collections constitute for the study of medical, social and often urban history as well is self-evident.

The new thinking that defines the last quarter of the twentieth century in Canadian archival studies reflects several developments that are distinct but, of course, related to one another. In the context of the emerging archival profession (the Association of Canadian Archivists and the journal *Archivaria* were both founded in 1975) and the corresponding establishment of formal graduate programs at the University of British Columbia (1981 – the first in North America) and subsequently at the University of Manitoba, the University of Toronto, the Université de Montréal

and Université Laval, we also see a new archival scholarship devoted to hospital and medical archives. The pioneering surveys conducted by this new cadre of archivists in due course also attracted new professionals into the field. As the archival profession became better informed about the work of hospital archives and better prepared to undertake the work they require, they also found themselves allies in the field of the new social history with an interest in hospital history and experience in coping with the limitations of hospital archives. *Archivaria* 10 and 41 are concrete signs of the existence and potential of this alliance. Finally, these advances within the archival and historical domain coincide with the new legal requirements of access and privacy legislation and the whole wave of challenges presented by the born-digital records.

In the scholarly efforts to identify the types of archives found in hospitals and the never-ending struggle to advise hospital administrators on the proper procedures for establishing and maintaining their archives, the most prominent figure is arguably Barbara L. Craig, whose ground-breaking work is complemented by the more specialized studies of scholars like Robin G. Keirstead or Elizabeth Denham.[2] More generally, the Association of Canadian Archivists conducted a survey of hospital

[2] Cf. Barbara L. Craig, "The Canadian Hospital in History and Archives," *Archivaria* 21 (Winter, 1985-1986), pp. 52-67; Robin G. Keirstead, "An Archival Investigation of Hospital Records" (unpublished M.A.S. thesis, University of British Columbia, Vancouver, 1985); Elizabeth Denham, "Dealing with the Records of Closing Hospitals: The Calgary Area Health Authority Plan," *Archivaria* 41 (Spring, 1996), pp. 78-87.

archives in 1979 and published a technical booklet in 2003 to guide and support the efforts of hospital archivists in setting up and developing their collections.[3]

It is in the latest developments in the domain of access and privacy, on the one hand, and in the entirely novel field of born digital records, on the other, that we may find cause for some optimism with respect to the ongoing task of putting hospital archives in Canada on a firmer footing. Although the tangible results of the push of the mid- to late-twentieth century were modest, these activities did establish a new paradigm within the archival world, and the newly developed hospital archives, though few in number, actually serve as models to which archivists can point in their discussions with hospital administrators.

Even the existence of hospital archives is still not well documented, and their location in the organizational structure seems diverse and, above all, fluid. For the most part, unfortunately, the institutional status of corporate archives in Canadian hospitals is low, their funding is unstable, and their prospects of survival beyond the term of a particular team of senior administrators is inherently precarious. At the same time, the preservation of the records that belong in such archives is clearly of significance to the well-being and future of the institution: they not only protect it against legal challenges that often arise unforeseen but also provide indispensable

[3] Craig, "The Canadian Hospital in History and Archives"; see also Association of Canadian Archivists, *Medical Archives* ([Ottawa]: Association of Canadian Archivists, 2003).

documents for any effort to define, establish and support their institutional identity and, at the same time, bolster and maintain their institutional morale. In exploring the history and present state of such archives, and always bearing in mind their distinction from medical/patient records, I rely on a review of the archival literature, a combination of a formal survey of institutions and selected case histories, and of course my professional experience. Special attention is being paid to the place of these archives within the corporate structure of the institution and to the arguments that have been made to establish and maintain the archives – or to abandon them.[4]

In view of the fact that the state of corporate archives in Canadian hospitals has not been documented in recent years, a new assessment was carried out as part of the present thesis project in the hope that it will provide a firm baseline for comparative and historical evaluation. It will also, it is hoped, respond to a number of important issues that have only arisen in the intervening years, from the advent of e-records to the complete collapse of the funding mechanism on which such archives had traditionally relied (for instance the Hannah Institute for the History of Medicine in Ontario). While this new assessment focuses on the types and place of the archives within the institutional structure of the hospitals, it also explicitly deals with historical questions such as the year in which the archives was founded; whether it had shifted from one place to another in the organizational structure; and if it had been closed

[4] The effect of the closure of entire hospitals on their archival collections is the subject of Elizabeth Denham's "Dealing with the Records of Closing Hospitals: The Calgary Area Health Authority Plan."

(and perhaps re-opened); etc. The results of the larger study confirm the tentative findings arrived at during the planning and preparatory phases of this project: the administrative archives of Canadian hospitals turn out to present a scene of great diversity, weakness, and promise. The significant limitations that emerge might well serve as a wake-up call to the institutions involved and perhaps also to the governments that provide the majority of healthcare funding. If these institutions are to be properly accountable for the vast amounts of public funding they receive, they need to take better control of their archives.

The thesis of which this survey project is an integral part begins with a general survey (Chapter 1) of the historical developments leading to the emergence of the modern general hospital as the primary facility for medical treatment and care of the entire population (rather than only the indigent and incurable, as was the case almost to the end of the nineteenth century). Together with a summary exploration of the types of historical sources, this provides the context for a review of the archival literature as it concerns hospital archives and their early history in Canada, in Great Britain and in the United States and of the more specialized documentation available in the literature with respect to corporate archives in Canadian hospitals (Chapter 2), with a special emphasis on the pioneering efforts of the 1980s and the extent to which they were subsequently implemented. In order to illustrate some of the typical issues encountered in the establishment and maintenance of hospital archives in Canada (Chapter 3), we examine the situation in a "stand-alone" hospital (Kingston General)

and in a metropolitan area that has experienced large-scale amalgamation (Calgary) as well as in the local case of the Health Sciences Centre, Winnipeg and the institutions from which it was created, most prominently the Winnipeg General Hospital. In presenting the methodology of the new survey followed by the results and their analysis (Chapter 4), special attention is paid to the way in which the surveyed population was established. The Conclusion offers suggestions on changes that could be made to enhance the functioning of hospital archives and their long-term value to the institutions of which they form a part.

CHAPTER ONE

THE RISE OF THE MODERN HOSPITAL

In exploring the historical development and current status of the corporate archives in Canadian healthcare institutions, we begin with a sketch of the historical context: a survey of the history of the institutions themselves and, at the same time, of the various ways in which their history has been treated.

A first wave of successive revolutions had by the turn of the twentieth century transformed the charitable refuges of the pre-modern era into bastions of science while their patients, who had until 1870 been mainly the indigent and incurably sick, were gradually being replaced by the sick of the entire population, rich or poor. In a second wave, hospitals and governments initially tried to deal with the growing economic demands of the hospital sector by segregating the classes, but the attempt to have the paying patients subsidize those who could not pay their own way soon failed and gave way to alternative models ranging from private insurance plans to universal healthcare systems run and funded by the state. The latter model ultimately became the norm in Canada as it had in much of Europe – and in the United States as well,

despite the staggering discrepancy between rhetoric and reality which Rosemary Stevens calls "a major conclusion" of her *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (1989): "that the United States has a de facto national health care system [...] although Americans are unwilling to recognize the fact and will indeed go to enormous lengths to deny it."[1]

The incessant calls for efficiency and accountability that became the hallmark of this second wave of revolutions persist into the present, and so does the accompanying move towards a managerial focus and an ever-growing degree of bureaucratization. While the consequences of these changes for Canadian hospital archives will be explored in Chapter 2 and 3, we need to distinguish the subject of this historical survey from the several others with which it overlaps or, at least, shares a boundary.

The fundamental distinction drawn in the Introduction (and to be discussed more fully in Chapter 2) between patient records and corporate records is reflected in the parallel distinction between the history of medicine in the narrow sense of that term and the history of healthcare institutions. To be sure, even the sharp boundary that has to be posited between patient records and institutional or corporate records shows occasional indeterminacies, for instance in the patient billing records or, in a

[1] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), p. 352.

more attenuated form, in the admission or occupancy records (which, even if they are limited to the patient's name, would still link this information to a particular hospital department – internal medicine, surgery, radiography, etc. – and the date and duration of the patient's stay). In the parallel domain of the history of medicine and the history of healthcare institutions, the historiographical practice suggests that the corresponding boundaries are much more permeable (or malleable) than those between patient and corporate records.

In the present study it seems most important to stress the distinction between the history of medicine and that of healthcare institutions since the archives with which we are concerned are invariably the institutional archives of hospitals (rather than the patient/medical records). In treating the history of hospitals as falling within the realm of the "societal aspects of medicine," as Wendy Mitchinson and Janice Dickin McGinnis call it in the introduction to their *Essays in the History of Canadian Medicine* in 1988, or, for short, the social history of medicine, we set it apart not only from the history of medicine in the narrow sense of that term but also from the scientific and clinical research that underpins medical theory and its application in medical schools and hospitals.[2]

[2] Wendy Mitchinson and Janice Dickin McGinnis (Eds.), *Essays in the History of Canadian Medicine* (The Canadian Social History Series, Toronto: McClelland and Stewart, 1988), p. 7.

The scope of the history of medicine is of course enormous and includes, among many other subjects, studies of diseases and epidemics,[3] new treatments and cures, and epidemiological patterns and vaccinations.[4] In another dimension it ranges from the biographies of great men and women to statistical healthcare policy research carried out on an institutional scale. It is not at all surprising, therefore, that both the historical treatment and the archival treatment of the material is extremely complex and uneven,[5] and that the distinctions drawn here are often ignored or at least blurred.

The corresponding variation in the terminology used is enormous. It is all the more important, therefore, to stress that the issues addressed in the present study are those of the *institutional identity* of hospitals and the corresponding archives and records management programs, and that it makes no claim whatsoever of dealing with the history of medicine as such.

The blurring of boundaries that seems endemic in this domain is hardly surprising since the history of medicine is not only a well-established branch of history but has often also been practised in faculties of medicine. Finally, it

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[3] See for example Esyllt W. Jones, *Influenza 1918: Disease, Death and Struggle in Winnipeg* (Studies in Gender and History, Toronto: University of Toronto Press, 2007).

[4] See for example Maurice Mierau, *Memoir of a Living Disease: The Story of Earl Hershfield and Tuberculosis in Manitoba and Beyond* (Winnipeg: Great Plains Publications, 2005).

[5] See for example Nancy McCall and Lisa A. Mix (Eds.), *Designing Archival Programs to Advance Knowledge in the Health Fields* (Baltimore: Johns Hopkins University Press, 1995) and Joan D. Krizack (Ed.), *Documentation Planning for the U.S. Health Care System* (Baltimore: Johns Hopkins University Press, 1994).

transcends both of these academic domains in the strong appeal it exerts on the general public. The publication history of two recent bestsellers may serve by way of illustration. In 1991, *Plague: A Story of Smallpox in Montreal* by Michael Bliss was published as a trade book by the strictly commercial house of HarperCollins, Toronto (rather than, say, by a university press). Even the much more compendious work, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* by Richard J. Evans, first published by the Clarendon Press of Oxford University Press in 1987, was quickly re-issued – along with all its copious archival references – as a Penguin paperback in 1990.[6]

The Historiographical Background: From Celebratory Volumes to the New Social History of Medicine

The history of the institutions in which the treatment of patients and much of scientific and clinical research takes place seems to have attracted remarkably little attention; as one eminent observer, C. David Naylor, puts it, "of all the areas of Canadian medical historiography, the general hospital remains one of the least explored."[7] Of course it would be simplistic to attribute this abstinence on the part of historians to the sorry state of the archives, but just as obviously this poverty does make them less than inviting. Not all archives are equally impoverished, however,

[6] Michael Bliss, *Plague: A Story of Smallpox in Montreal* (Toronto: HarperCollins Publishers, 1991); Richard J. Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (Oxford: Clarendon Press, 1987).
[7] C. David Naylor (Ed.), *Canadian Health Care and the State: A Century of Evolution* (Montreal and Kingston, Ontario: McGill-Queen's University Press, 1992), p. 8.

and there are a few general studies, many of them devoted to a particular sector of the field, notably to religious institutions or the "voluntary public general hospitals" of Gagan and Gagan.[8] The most common type of work is the monograph devoted to a particular institution, aptly (though perhaps not without a touch of malice) labelled "'in-house' or 'do-it-yourself' publications" by the professional historian of medicine, J.T.H. Connor, whose phrase recurs in a less provocative form in the more broadly defined "house histories" of Naylor.[9] It is typical of such studies that they are put together by a committee (often anonymous) normally composed of insiders, both current and retired staff, with rich stores of institutional memory. As a result, many of them hint at places where historical documents are kept – and from where they might be retrieved for placement in a proper archives.

Among the relatively small number of histories devoted to individual institutions, J.T.H. Connor's study of the Toronto General Hospital, which appeared in 2000, and W.G. Godfrey's stupendous history of the Moncton Hospital, published in 2004, deserve special mention.[10] They are beacons of the new social history of

[8] David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal and Kingston, Ontario: McGill-Queen's University Press, 2002).

[9] J.T.H. Connor, "Hospital History in Canada and the United States [review essay]," *Canadian Bulletin of Medical History* 7 (1990), p. 94; C. David Naylor, *Canadian Health Care and the State: A Century of Evolution* (Montreal and Kingston, Ontario: McGill-Queen's University Press, 1992), p. 3; For typical examples see St. Boniface General Hospital, *The Book of St. Boniface* (Winnipeg, 1930); Max Braithwaite, *Sick Kids: The Story of the Hospital for Sick Children in Toronto* (Toronto: McClelland and Stewart, 1974); Health Sciences Centre, *Healing and Hope: A History of Health Sciences Centre Winnipeg* (Winnipeg: Health Sciences Centre, 2009).

[10] J.T.H. Connor, *Doing Good:The Life of Toronto's General Hospital* (Toronto: University of Toronto Press, 2000); W.G. Godfrey, *The Struggle to Serve: A History of the Moncton Hospital, 1895 to 1953*

medicine (to be discussed more fully below) and constitute part (along with a few other titles) of a defining set with C. David Naylor's thematic analysis of hospital funding and the splendid comparative study of the voluntary general hospital of David Gagan and Rosemary Gagan.[11]

A fundamental reason why the potential wealth of archival documentation has not borne fruit nearly as fully as might have been expected is poignantly illustrated by the recurring lament about the state of the archival collections, which seems to be a commonplace of many scholarly works. Gagan and Gagan, for example, in their otherwise hard-hitting study of public hospitals, choose a strikingly impersonal turn of phrase when they speak of "the growing imperative to preserve institutional records."[12] Similarly, J.T.H. Connor's review essay on the historiography of healthcare, well known for its remark about "the impending epidemic of 'centennialitis'," also remains fairly general when he touches on "archival caches" that await being revealed,[13] and Peter L. Twohig ends his bibliographical survey article of 2002 with a similar appeal: "Historians of health care need also to be

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(Montreal and Kingston, Ontario: McGill-Queen's University Press, 2004). For a more comprehensive listing (though still called "selective"), as of 2004, see Godfrey, *The Struggle to Serve,* Introduction, n. 4.

[11] Naylor (Ed.), *Canadian Health Care and the State*; Gagan and Gagan, *For Patients of Moderate Means*.

[12] Gagan and Gagan, *For Patients of Moderate Means*, p. 9.

[13] Connor, "Hospital History in Canada and the United States," pp. 94, 103-104.

advocates for the preservation of material culture and of documentary sources (and access thereto)."[14]

In fact, of course, the relative scarcity of professionally authored hospital histories may well be a fairly direct reflection of the lack of professionally designed and maintained hospital archives. This issue is explicitly addressed – though not quite as boldly as in the hypothesis just suggested here – in William Godfrey's history of the Moncton Hospital.[15] First of all Godfrey offers a vivid portrayal of "what is described in this study as the Moncton Hospital Archives," which, in his words, "remains a small room in the hospital library with its documentation largely unorganized and unprocessed."[16] He then goes on to provide a remarkably rich and impressive survey of the many types of records that have survived in spite of neglect (and moves and a fire) and have been preserved in a variety of different archives. In general, however, he bluntly condemns both "the primary sources" and "the literature on hospitals" as "distressingly inadequate."[17]

Despite the handicap presented by the sorry state of hospital archives, the seminal work of such scholars as Connor, Gagan and Gagan, Godfrey or Naylor, to name but a few, amounts to a splendid response to Samuel Shortt's call urging

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[14] Peter L. Twohig, "Recent Writing on Health Care History in Canada," *Scientia Canadensis: Canadian Journal of the History of Science, Technology and Medicine* 26 (2002), p. 27.
[15] Godfrey, *The Struggle to Serve*.
[16] Ibid., p. 6.
[17] Ibid.

"historians to bring Canadian hospital history into the broad stream of Western historical medical scholarship."[18]

The use of this term, 'New Social History of Medicine', in the title of Shortt's paper echoes the title of Henry Sigerist's classic essay of 1941 about the social implications of medical history.[19] In view of the practical archival issues that lie at the heart of the present thesis, it deserves to be stressed here that Sigerist was not only an eminent historian of medicine but also a very hands-on contributor to the history of healthcare in Canada: in 1944 he served as a one-man commission to assess the healthcare situation in Saskatchewan for the newly elected CCF government of T.C. Douglas, completing the task in just four weeks![20]

In reviving the term forty years later, Shortt explicitly rejects the tradition of medical history "written by doctors, about doctors, and for doctors." He acknowledges the validity of the widely recognized problem that "research materials are obscure or, as in the instance of hospital case notes, for example, non-existent or inaccessible" but, turning to the historiography of institutional histories, summarily

[18] Samuel E.D. Shortt, "The New Social History of Medicine: Some Implications for Research," *Archivaria* 10 (Summer, 1980), pp. 5-22.
[19] Henry Sigerist, "The New Social History of Medicine," *Western Journal of Surgery, Obstetrics and Gynecology* 48 (October 1941), pp. 714-722.
[20] Saskatchewan Health Services Survey Commission, *Report of the Commissioner* (Regina, 1944); cf. Gagan and Gagan, *For Patients of Moderate Means*, p. 95.

condemns them as "usually [...] so thin and lacking in critical framework as to be of almost no use to succeeding scholars."[21]

Instead of celebratory or hagiographic works or "empty chronologies," Shortt pleads for analytical studies based on a completely different set of data. First, the diaries, letters and memoirs of physicians (and the "sterile reports written by governors or physicians") need to be complemented by the letters and other personal records of patients if the iatrocentric view of things is to be balanced by that of the other population at the core of the hospital scene (along with that of the non-medical staff in all its variety). Of course there are also government records, published reports, journals, biographies, association proceedings and the like, and finally he suggests a much broader repository which "might well [include] hospital records, fee bills, insurance manuals, industrial and union records, reports from government departments such as immigration, pharmacy records and medical journals and proceedings."[22] These are the classes of records at least some of which would typically be preserved in the administrative archives of a hospital.

From the archivist's perspective, the key effect of the change urged by Shortt is this: social historians of medicine will be looking for vastly different sources than practitioners of the traditional history of medicine. Conversely, contemporary

[21] Shortt, "The New Social History of Medicine," pp. 5-8.
[22] Ibid., p. 21.

historians are unlikely to be as enthusiastic about the establishment of a distinct medical archives as were their more traditional predecessors, even if such a concept still seems well suited to either an iatrocentric or a disease-oriented approach.

But Shortt goes far beyond either of these approaches when he lists "equally fruitful sources" which may be held in a variety of archives: "manuscript diaries and travel accounts, transcripts of malpractice suits and coroners' inquests, medical advertisements in the lay press, sermon and devotional literature, census data, and parish records"[23] – in short, the new social historians know few limits in casting their nets.

In the light of these programmatic statements, it is remarkable how far some of the new social historians did in fact range. In W.G. Godfrey's study of a single institution and its setting, the Moncton Hospital as it evolved between 1895 and 1953, the archivist reader is struck first and foremost by his tale of three successive sites and the 1956 fire that destroyed the hospital's medical library in which the archives were housed. As a consequence, Godfrey found merely "a small room in the hospital library with its documents largely unorganized and unprocessed." The gentle tone of his Introduction (where he surveys his sources on pp. 6-8) gives way to a more direct and judgmental comment in the opening section of his Bibliography (where he gives

[23] Ibid.

fuller details of his archival sources on pp. 221-222): "the Moncton Hospital Archives remains a neglected part of the hospital library."[24]

The primary sources he and his research assistants found there, despite obvious shortcomings, were supplemented primarily by the holdings of the Provincial Archives of New Brunswick and the library of Mount Allison University. In the order he presents them, they range from an almost complete set of annual reports (1899-1965) and minutes of meetings of the hospital board and of various committees to extensive correspondence and reports commissioned by the hospital board. In addition to acts of incorporation and their amendments and the hospital bylaws, there are architects' studies and brief histories of such specific groups and units as the Ladies' Aid, the nursing school, the early x-ray department and the "hospital service in Moncton" (presumably the outpatient department). He specifically mentions the extensive press coverage which hospital matters received during the first half of the twentieth century, citing the *Daily Times* as his source of choice. At the Provincial Archives of New Brunswick, the records of the Provincial Department of Health provided copious hospital correspondence, reports and studies no longer to be found in the Moncton Hospital Archives. They also hold the Moncton municipal records, those of the Department of Public Works and of several successive Premiers of the province, and the annual Acts of the Legislature of New Brunswick along with the records of the Royal Commission Studying Hospital Services of 1902. (For the

[24] Godfrey, *The Struggle to Serve*, pp. 7, 221.

annual reports of the Board of Health, a variety of local, regional and national census reports and a long run of city directories, Godfrey relied on the library of Mount Allison University.) Finally, the Provincial Archives of New Brunswick offered a copious set of records concerning Francis P. Murphy, a member of the board who in 1916 challenged its composition in a *cause célèbre* that made its way through the public courts all the way to the provincial legislature.[25]

In addition to the records listed, all presumably public, Godfrey also used an "undocumented manuscript" containing "a wealth of information and anecdotes" that he was given during the early phase of his research and which forms part of a work that has since appeared in print.[26] He describes the author as a "long-time staff physician" who obtained permission to examine the personnel records of the physicians employed by the hospital.[27]

In contrast to the majority of hospital histories, which restrict themselves to a single institution, the comparative (or "synthetic") study of the Gagans deals with no fewer than ten hospitals, ranging from coast to coast (Halifax to Vancouver) and including, along with the usual metropolitan hospitals (and omitting those of the Province of Québec), the Owen Sound General and Marine Hospital to which David

[25] Ibid., pp. 6-8, 221-222.
[26] Donald I. McLellan, *History of the Moncton Hospital: A Proud Past – A Healthy Future (1985-1995)* (Halifax: Nimbus Publishing, 1998).
[27] Godfrey, *The Struggle to Serve*, pp. 7-8.

Gagan had devoted an earlier book in 1990). Among their sources for the Winnipeg General Hospital, which plays a fairly prominent part in this book, Gagan and Gagan list the Public [*sic*] Archives of Manitoba (now called the Archives of Manitoba) and both the University of Manitoba Archives and the University of Manitoba Faculty of Medicine Archives, but their archival references are limited to the Winnipeg General Hospital collection in the Archives of Manitoba on the one hand and the Sessional Papers of the Legislative Assembly of the Province of Manitoba on the other, notably containing the annual reports of the Department of Public Works (1903) and the Department of Health / Department of Health and Public Welfare (1930-1950), various published reports (especially from the 1940s), and, most frequently cited, the 'Second Interim Report of the Public Welfare Commission of Manitoba' of 1919.

In the Winnipeg General Hospital collection in the Archives of Manitoba, the primary source on which Gagan and Gagan relied are the annual reports of the Winnipeg General Hospital,[28] which are not only quoted copiously but also exploited in an impressive set of statistical appendices. 'Medical Staff Minutes' are quoted for 17 November 1913 and 25 August 1914; among what appear to be individual documents, the collection also includes a 'Visitors' Committee Report Book' dated 20 September 1891 and a document identified solely as 'Gas Gangrene Infection 1921' (in Box 27), with the corresponding text obliquely referring to Professor Jasper

[28] They are cited as 'Annual Report' by Gagan and Gagen even though the titles in fact show some variation over the years; see also Chapter 3.

Halpenny.[29] Finally, the Gagans' chapter on nursing (chapter 5, "Better, Brighter, and Kinder Nurses") contains numerous quotations, by name and tape number (and sometimes date, too), from interviews recorded in the course of an oral history project (in 1987-1988) entitled 'Nurses and their Work: Oral Histories of Nurses in Winnipeg, 1920-1940.'[30]

The Diversity of Canadian Hospitals

The great diversity in history, status, and structure of hospitals in Canada has left its traces in archival situations of many different types; different organizations manage their records differently and leave behind an extraordinary variety of documentary collections. The earliest hospitals were typically set up by religious orders and normally form part of a larger organization, and it is often difficult to identify and retrieve the healthcare portion of these fonds. The St. Boniface Hospital, the early records of which were transferred to Montreal by the Grey Nuns a few years ago, offers a classic example.[31] Secular healthcare facilities were often founded by prominent citizens, whether in response to epidemics or as part of a more general campaign to enhance the pride and glory of their city. The establishment of the Winnipeg General Hospital, for example, was largely the work of Andrew Bannatyne

[29] Gagan and Gagan, *For Patients of Moderate Means*, passim; p. 174.
[30] This project was a joint venture between the Winnipeg General Hospital School of Nursing Alumnae Association and Kathryn McPherson (then a doctoral candidate in Canadian History at Simon Fraser University). The tape recordings are available both at the Archives of Manitoba and at the Health Sciences Centre Archives/Museum (where their reference is F1;A2;S4).
[31] Jacinthe Duval, then Archivist at the St. Boniface Historical Society, personal communication, ca. 2007; some of the records, however, seem to remain at St. Boniface.

and Andrew McDermot, both major entrepreneurs whose names still grace nearby streets.[32]

Other hospitals were devoted to specific sectors of the population, most commonly to either women or children. The Winnipeg General's Maternity Hospital, for example, which succeeded an earlier maternity hospital run by the Christian Women's Union since 1883, opened its doors in 1888, simultaneously with the opening of the new St. Boniface Hospital across the river.[33] Not only were the medical needs of these groups of patients seen to be specific, but they also called for bedside care of a specialized sort. As in the case of the general hospitals, the more specialized institutions too were founded by small groups of activists and sometimes even by individuals, a striking example being that of Annie A. Bond at the Children's Hospital of Winnipeg, opened in 1909.[34] In metropolitan centres, they were often members of notable families such as in Toronto, where the Gooderham family endowed both the Hospital for Sick Children[35] and the Holland Bloorview Kids Rehabilitation Hospital (later simply the Holland Bloorview).[36]

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[32] See Health Sciences Centre, *Healing and Hope*.
[33] Ian Carr and Robert E. Beamish, *Manitoba Medicine: A Brief History* (Winnipeg: University of Manitoba Press, 1999), pp. 32, 33; see also Board of Trustees Minutebooks, 1888, Winnipeg General Hospital, MG10 B11/Box15, Archives of Manitoba.
[34] Harry Medovy, *A Vision Fulfilled: The Story of the Children's Hospital of Winnipeg, 1909-1973* (Winnipeg: Peguis Publishers, 1979), p. 3.
[35] See Braithwaite, *Sick Kids*.
[36] The writer as Archives Co-ordinator at Bloorview MacMillan Children's Centre, 2003.

The same general patterns are also found in the case of hospitals treating other, and often more specialized, conditions. The original patients of the Holland Bloorview were 'crippled children' – Holland Bloorview is a merger of the Home for Incurable Children and the Ontario Crippled Children's Centre – and the same holds for the Shriners' Hospital in Winnipeg that flourished from 1928 to ca. 1979 and became the Rehabilitation Centre for Children.[37] Perhaps the most infamous types are, from the earliest times, psychiatric institutions (famously portrayed by Michel Foucault and more recently by Geoffrey Reaume in his work on patients at the Queen Street Mental Health Centre in Toronto) and, in the twentieth century, tuberculosis sanatoria (which for Manitoba have been the subject of important studies by Thorpe and by Mierau).[38] Another type that has a very long history is represented in Winnipeg by the Military Convalescent Hospital for Returning Soldiers, founded in 1916 and more recently transformed from a Veterans Affairs Canada Hospital into an Operating Division of the Winnipeg Regional Health Authority known as Deer Lodge. Even a brief overview, finally, has to include reference to what may have been a Canadian peculiarity – the 'immigrant hospital', which in the case of Winnipeg had been promised at least as early as 1880 (rather than the 1897 date given

[37] Medovy, *A Vision Fulfilled*, p. 133.
[38] Michel Foucault, *History of Madness* (London: Routledge, 2006); Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2009); Ethel L. M Thorpe, *The Social Histories of Smallpox and Tuberculosis in Canada: Culture, Evolution and Disease* (University of Manitoba Anthropology Papers, 30. Winnipeg: Department of Anthropology, University of Manitoba, 1989); Mierau, *Memoir of a Living Disease.*

by Robert Vineberg[39]): "In January 1881, the Dominion Government having decided to postpone the carrying into effect of their previously announced decision to erect an immigrant hospital in Winnipeg, [...]."[40] Unlike those of the port cities, Winnipeg's immigrant hospital was designed to treat, rather than merely quarantine, immigrants who had fallen ill on the way to their new life in Manitoba.

Each of the above types of hospital produced records, but there are vast differences in the kinds of documents they generated, in the way these were organized, and in the repositories in which they ended up. This general pattern of immense diversity has become even more complex as many hospitals became affiliated with other institutions (such as faculties of medicine) or were taken over by larger organizations such as regional healthcare authorities.

With all this diversity, these institutions share one common trait: the existing literature – most prominently the individual institutional histories – offer very little *explicit* information about their administrative records and their archives.

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[39] Robert Vineberg, "Welcoming Immigrants at the Gateway to Canada's West: Immigration Halls in Winnipeg, 1872-1975," *Manitoba History* 65 (Winter, 2011), pp. 13-22.

[40] *Winnipeg General Hospital, Report of the Secretary-Treasurer from April 1, 1882, to December 31, 1883, with a list of the Life Governors and Annual Subscribers entitled to vote at the Annual General Meeting, February 11, 1884* ([internally dated:] January 30, 1884), p. 10; Health Sciences Centre Archives/Museum, F4; S4.

From Diversity to Uniformity

As diverse as these institutions obviously were in their earliest forms and as dramatically as they may have differed in size and scope, they gradually underwent changes that, by the dawn of the twentieth century, resulted in a much more uniform hospital scene.

The founding phase that had begun shortly after initial colonization, with the earliest dates marked by the arrival of the Ursulines in Québec, reached its climax and end with the settlement of the prairies and the Pacific coast. The establishment of the Winnipeg General Hospital in 1874 (see also chapter 3) may be taken as representative. These were "the heady days of community hospital boosterism,"[41] and while we have histories – by doctor and nurse, respectively – of the Children's Hospital and the Winnipeg General Hospital School of Nursing,[42] it seems remarkable that there exists no similar volume that would reflect this spirit and relate the struggles of the Winnipeg General Hospital, for example, in a progress-inspired fashion. There is only the boosterist lecture of Mrs. George Bryce (i.e., Marion Bryce) published in the 1899 volume of the Transactions of the Manitoba Historical and Scientific Society;[43] their narrative of *Manitoba Medicine* obviously casts a much wider net but the same spirit is still recognizable in the occasional 'kindly old fellow'

[41] Gagan and Gagan, *For Patients of Moderate Means*, p. 47.
[42] Medovy, *A Vision Fulfilled*; Ethel Johns and Beatrice Fines, *The Winnipeg General Hospital and Health Sciences Centre School of Nursing, 1887-1987* (Centennial Edition, Winnipeg: Alumnae Association, Winnipeg General Hospital and Health Sciences Centre School of Nursing, 1988).
[43] Mrs. George Bryce [i.e., Marion Bryce], "Historical Sketch of the Charitable Institutions of Winnipeg," *Transactions of the Manitoba Historical and Scientific Society, 54,*1899, pp. 1-11.

tone of Drs. Ian Carr and Robert E. Beamish.[44] Although this earliest phase of hospital development in Canada had in fact begun at various times depending on the site's location on the east-to-west trajectory, it drew to its conclusion more or less simultaneously for all hospitals in Canada towards the end of the nineteenth century.

Unbeknownst to the participants in this historical process, the critical step that ultimately resulted in a remarkable degree of uniformity was methodological and scientific in nature but its most striking consequences were social. It was the discovery of antiseptic (and, later, aseptic) technique which within half a century (and despite the rearguard actions, at one time or another during this process, of much of the medical profession) made the hospital, which had until then been above all a place for "indigents, incurables and the chronically ill,"[45] safe for medicine and the paying classes.

The opening round in the medical revolution of 1847, almost completely overlooked and ignored in the bloody riots and counter-riots that were shortly to take place on the streets of most European capitals, were the observations of the obstetrician Ignaz Philipp Semmelweis (1818-1865). Having noticed a differential incidence of puerperal fever in the two public maternity wards of the general hospital of Vienna, he demonstrated that the infection and mortality rate could be reduced

[44] Carr and Beamish, *Manitoba Medicine.*
[45] Gagan and Gagan, *For Patients of Moderate Means*, p. 75.

dramatically if physicians washed their hands in an antiseptic solution of chlorine between performing autopsies and examining their living patients.

Although most of the early reports of Semmelweis's work were written by others,[46] they include a lecture by C.H.F. Routh before the Royal Medical and Surgical Society in London in November 1848 which rated both an account in *The Lancet*, still in 1848, and a lengthy publication in the *Medico-Chirurgical Transactions* (the precursor first of the *Proceedings*, and now the *Journal, of the Royal Society of Medicine*) in 1849.[47] Semmelweis's own book, published at Vienna in 1861, was not in fact translated into English until 1983.[48]

In the English-speaking world, the antiseptic technique that was proven experimentally well before the bacteriological facts of their causation were properly understood is firmly associated with the name of Joseph Lister (1827-1912), the Scottish surgeon who demonstrated the effectiveness of carbolic acid solutions in disinfecting both instruments and wounds. (Lister also closely followed the work of

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[46] The earliest reports were in two articles by his colleague Ferdinand Hebra that were published in Vienna in 1847 and 1848.

[47] C.H.F. Routh, "On the causes of the endemic puerperal fever of Vienna," *The Lancet*, vol. 2, 1848, pp. 642-643; C.H.F. Routh, "On the causes of the endemic puerperal fever of Vienna," *Medico-Chirurgical Transactions*, vol. 32, 1849, pp. 27-40.

[48] Ignaz Semmelweis, *Etiology, Concept and Prophylaxis of Childbed Fever*, tr. by K. Codell Carter (Wisconsin Publications in the History of Science and Medicine, 2; Madison: University of Wisconsin Press, 1983); cf. also K. Codell Carter and Barbara Carter, *Childbed Fever: A Scientific Biography of Ignaz Semmelweis* (Westport, Connecticut: Greenwood Press, 1994) and K. Codell Carter, *The Rise of Causal Concepts of Disease: Case Histories* (The History of Medicine in Context; Aldershot, Hants.: Ashgate Publishing, 2003), especially chapter 3, 'Etiological Characterizations.'

Louis Pasteur, whose first study of "living ferments" had appeared in print in 1857 as "Mémoire sur la fermentation appelée lactique;" Lister's own results were published in a series of six articles in *The Lancet* in 1867.) From the perspective of historiography, it is worth noting that Carr and Beamish, in their short history of medicine in Manitoba, actually mention Semmelweis and Pasteur but not Lister;[49] none of the three figures in their index.

Within another two decades, the bacteriological foundations to undergird the pioneering experiments in antisepsis of Semmelweis and Lister had been laid by Louis Pasteur (1822-1895) and others. The adoption of handwashing as an antiseptic technique, however, appears to have proceeded somewhat haltingly. In a 1945 textbook used in the Winnipeg General Hospital School of Nursing, for instance, it is reported as a "respectable and established procedure" in surgery, obstetrics and communicable diseases by 1860 but only "more recently," it appears, has it been "extended to medicine and pediatrics."[50] In the Maternity Hospital, in fact, the principle in question – if, perhaps, not the technique based on it – was obviously accepted from the outset, in 1888, as illustrated by the following pledge required of all medical students before they would be admitted to the ward:[51]

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[49] Carr and Beamish, *Manitoba Medicine*, p. 32.
[50] L.R. Thompson, *Introduction to Microorganisms* (Philadelphia and London: W.B. Saunders, 1945), p. 401; cited from copy in Health Sciences Centre Archives/Museum Special Collection.
[51] Board of Trustees Minutebooks, 8 October 1888, Winnipeg General Hospital, MG10 B11/Box15, Archives of Manitoba; see also Emma Prescott, "1888 Building Boom: Maternity Hospital," *HSC Focus*, vol. 20, no. 7 (26 July 2013), pp. 6-7.

> I the undersigned student do hereby solemnly declare that I will not visit or be present at cases of confinement in the Maternity Hospital when engaged in pathological operations, when recently engaged in dissection, or when dressing putrid sores, under penalty of expulsion.

The revolution caused in hospitals by the discovery of antiseptic, and soon aseptic, technique and the subsequent discovery of the bacteriological processes which they interrupted, that is, the "germ theory of disease" took half a century to develop but it took almost as long again to be implemented. In his history of the American hospital system, Charles Rosenberg offered a harrowing account, in the section on 'Banishing Infection: The Measured Triumph of Antisepsis,' of how slowly the practice of antisepsis took root in United States hospitals.[52] The Gagans may have been overly optimistic in their claim that, by the turn of the twentieth century, "asepsis – a contagion-free environment – became the standard in hospitals in Europe and North America."[53] From the perspective of historiography, finally, it is worth noting that Rosenberg, too, restricts himself to Lister and Pasteur as the pioneers of antisepsis; there is no mention of Semmelweis.

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[52] Rosenberg, *The Care of Strangers*, pp. 144-147.

[53] Gagan and Gagan, *For Patients of Moderate Means*, p. 28; for a general discussion of the distinction between antiseptic and aseptic technique see Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (The Canadian Social History Series, Toronto: Oxford University Press, 1996), pp. 86 ff., 'The Germ Theory Meets Scientific Management.'

In the long run, and regardless of the issue of precedence, the cumulative effect of the discoveries in question was momentous, and their ramifications were to change society as a whole for the foreseeable future. As Gagan and Gagan put it, "Science had set the stage. Social change had defined the cast."[54]

Until this time, hospitals had overwhelmingly been places for the poor and the incurable. Now, quite suddenly, they promised therapeutic advantages that challenged the model of treatment at home which had been the norm for all that owned a suitable home and could afford the private services of physicians and nurses. As Gagan and Gagan point out, the change was massive, involving not only "the wholesale transfer of the care and treatment of the sick from the home to the hospital" but also the transfiguration, within a single generation, of the hospital from a "benevolent institution for the relief of the sick poor" to a place "for medical treatment and care for all classes in society."[55]

These startling transformations, to paraphrase the Gagans, took place between 1890 and 1914, and they affected both the hospitals themselves and the way they were viewed by the public. At the same time, the hospital scene saw expansion on an unprecedented scale; as the Gagans put it, "hospitals were no longer charities. They

[54] Ibid., p. 40; the analysis throughout this chapter relies heavily on Gagan and Gagan, *For Patients of Moderate Means*, and on Godfrey, *The Struggle to Serve*.
[55] Gagan and Gagan, *For Patients of Moderate Means*, pp. 6; 3.

were now [...] industries."[56] Manitoba, for example, had four hospitals in 1897, two of them in Winnipeg; by 1930, 24 more had been added in 20 communities.[57] The effect of these changes was obvious and measurable. In 1904, for example, Winnipeg had a higher death rate from typhoid (at 24.85 per 10,000) "than any other North American or European city."[58] By 1945, only one long generation later, Manitoba boasted "a medical system better than many and as good as any but a few."[59]

The role of the hospital as an efficient machine for the dispensation of medical services, run like a business along Taylorite lines of maximal efficiency and parsimony, was significantly enhanced by the technological innovations that became an indispensable part of hospital treatment early in the twentieth century. While their impact cannot be compared to that of antisepsis and asepsis, based on the germ theory of disease, they nevertheless offered a vastly improved diagnostic tool kit that, at the same time, corroborated the physicians' clinical judgement by objective, scientific measurements. In discussing these modern technologies, Joel D. Howell in his *Technology in the Hospital* concentrates on three in particular: x-ray imaging, blood tests, and urinalysis.[60] In examining both their medical value and their social meanings, Howell points out that urinalysis was not only the least invasive of the

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[56] Gagan and Gagan, *For Patients of Moderate Means*, p. ix; 4.
[57] Ibid., pp. 48-49.
[58] Alan F.J. Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914* (Montreal and London: McGill-Queen's University Press, 1975), p. 231.
[59] Carr and Beamish, *Manitoba Medicine*, p. 7.
[60] Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: The Johns Hopkins University Press, 1995).

three but also the most familiar: it had been in use, though in a mainly pre-scientific fashion, for centuries. On the other hand, it also required the least amount of new (and expensive) machinery. The same was far from the case for the other two. In the analysis of blood, for example, the counting of red and white cells and the differential proportions of various subtypes of white cells raised problems of interpretation which remain in dispute; in other blood tests, the results are more clearcut, for instance when the presence of the parasite responsible for malaria can be directly demonstrated. The introduction of x-ray technology is the most straightforward example: once the equipment became available, its use very quickly became routine, much as in the case of the successive imaging technologies (e.g., computer tomography, magnetic resonance imaging, positron emission tomography) of a hundred years later. What all these highly technical operations had in common, is that they quickly led to the establishment of specialized laboratories run by experts and to enormous and seemingly endless increases in cost.

Finally, the medical, organizational and financial success of laboratory medicine was matched or even exceeded by the triumphant progress of pharmaceutical innovation. The name of John Gerald FitzGerald, for instance, while hardly a household name like those of Banting and Best, is celebrated for his establishment of the University of Toronto Antitoxin Laboratory. The subsequent mass production of vaccines (crucially funded by Albert Gooderham, who was also responsible for naming the Laboratories after the Duke of Connaught) was a major

accomplishment.[61] In Winnipeg, where large numbers of troops were mobilized for World War I, typhoid inoculations which "commenced as a voluntary measure on the part of the [Winnipeg General] Hospital for the local Militia" ultimately led to the Pathology Department inoculating nearly 4,000 men by the end of 1914, covering "all the troops at present mobilized in Winnipeg."[62] The vaccine in question was used only at the Winnipeg General Hospital "and a few others supplied by it;" since "in the Winnipeg General Hospital vaccine the organisms are killed by means of formalin without heat," it differed fundamentally "from that used by the British and United States armies."[63]

In the general population, to be sure, the accomplishments of vaccination campaigns rarely cause as much excitement as the discovery of new therapeutic drugs, most dramatically illustrated by the discovery of the sulfonamide family of drugs in the late 1930s and, shortly thereafter, that of penicillin and the other antibiotics. But before the brilliance of the solitary researcher could become useful, the discovery in principle had to be developed on a massive industrial scale. In Rosemary Stevens's judgement, in her classic study, *In Sickness and in Wealth:*

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[61] For the history of J.G. FitzGerald and the Connaught Laboratories, see James FitzGerald, "The Troubled Healer," *U of T Magazine* (Spring 2002); for another comment on FitzGerald's status see Janice Dickin McGinnis, "From Salvarsan to Penicillin: Medical Science and VD Control in Canada," in Wendy Mitchinson and Janice Dickin McGinnis (Eds.), *Essays in the History of Canadian Medicine* (The Canadian Social History Series, Toronto: McClelland and Stewart, 1988), pp. 126-147; p. 128.

[62] Winnipeg General Hospital, *Reports and Accounts [for] 1914*, Report of the Superintendent, p. 28; Report of Pathological Department, p. 43.

[63] Sydney J.S. Peirce, "Antityphoid Inoculation at the Winnipeg General Hospital," *Canadian Medical Association Journal*, vol. 4, no. 10, 1914, pp. 890-893.

American Hospitals in the Twentieth Century (1989), "Production of penicillin was the outstanding example of the success of organized national medical research in World War II."[64]

If it had taken only one generation to establish the modern hospital, it took only one more for the promise of affordable hospital treatment and care to disappear beyond the reach of more than half of Canada's households.[65] The next revolutions, consequently, were economic and social. The financial health of all these institutions engaged in cycle upon cycle of technological innovation and expansion was inherently precarious, and so was their pattern of dependence on the fees of the well-to-do patients to cross-subsidize the treatment and care of the indigents. In trying to deal with these issues and at the same time with the struggles within the medical profession for ever greater shares of the spoils, the boards running the hospitals, which in the case of the increasingly dominant institutions of the voluntary general type were typically composed "of the best and most capable and responsible persons in the community," as the Gagans[66] cite the annual report of the Manitoba Department of Public Works of 1903, found themselves engaged in perennial confrontations with another pillar of society: the physicians.

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[64] Stevens, *In Sickness and in Wealth*, p. 202.
[65] Gagan and Gagan, *For Patients of Moderate Means*, p. ix.
[66] Ibid., p. 44.

Luckily for both, much of the labour required to run the day-to-day patient care could be extracted at minimal costs from the nursing students attracted to the rapidly growing number of hospital-based nursing schools. In 1902, for example, nursing students at the Winnipeg General Hospital School of Nursing wrote to the Board of Directors to protest the firing of four graduate nurses. One of the writers was Ethel Johns, later the author of a history of the Winnipeg General Hospital School of Nursing, who put the point succinctly in an unpublished manuscript quoted by Kathryn McPherson in her *Beside Matters*: "The directors knew only too well that if the student work force were to be withdrawn the hospital would be forced to close its doors."[67]

The quality of the nursing schools was notoriously uneven, and with the new century came repeated efforts to standardize and professionalize the education of nurses. Manitoba, for example, was only the second jurisdiction in Canada, in 1912, to introduce the formal registration of nurses.[68] The Weir Report of 1932, an enormously detailed (and on occasion quite opinionated) statistical study which

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[67] McPherson, *Bedside Matters*, p. 46; McPherson's n. 48 credits an "unfinished autobiography cited in Margaret M. Street, *Watch-fires on the Mountains: The Life and Writings of Ethel Johns* (Toronto: University of Toronto Press, 1973), p. 26." Ethel Johns's history of the Winnipeg General Hospital School of Nursing appeared in an informal edition in 1957: *The Winnipeg General Hospital School of Nursing, 1887-1953* ([Winnipeg: Winnipeg General Hospital School of Nursing Alumnae Association]) and an updated revision in 1988, by Ethel Johns and Beatrice Fines: *The Winnipeg General Hospital and Health Sciences Centre School of Nursing, 1887-1987.* Centennial Edition. (Winnipeg: Alumnae Association, Winnipeg General Hospital and Health Sciences Centre School of Nursing).

[68] Sheila Dresen, *The History of the College of Registered Nurses of Manitoba: Our Roots, Our Path, Our Evolution* (Winnipeg: College of Registered Nurses of Manitoba, 2012).

marks a milestone in these efforts, counted no fewer than 20 nursing schools in Manitoba alone (compared to only 29 in Québec and 218 in all of Canada).[69] As McPherson points out, it is also the only study to have examined the social background of Canadian nurses.[70] While it would go far beyond the scope of this brief historical survey, the social organization of healthcare institutions is a major topic in its own right. In general, it seems to replicate the structure of the larger society. Thus, hospitals have traditionally been sharply stratified, showing a top layer of highly paid physicians and administrators (mostly male), a middle group of mostly female nurses, therapists and technicians, and a bottom class of blue-collar workers showing an unmistakeable overrepresentation of minority groups. At the Winnipeg General Hospital, for example, the "first organized kitchen" was run from 1905 until 1936 (and on into the 1950s) by an "all Chinese staff."[71] In Rosemary Stevens's summary, "hospital staffing is still a good reflection of contemporary class, gender, and racial relations."[72]

Public Funding and Accountability: Bureaucratization

The Great Depression brought the various structural crises to a head. As the paying patients began to withdraw from the hospitals since they were less and less

[69] George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932), p. 249.
[70] McPherson, *Bedside Matters*, pp. 120 ff.
[71] [anon.], "Brother and Sister Remember Chinese Dynasty in Kitchen," *CentreScope* [Health Sciences Centre, Winnipeg], vol. 10, no. 7 (September/October 1982), p. 4; see also Health Sciences Centre, *Healing and Hope*, p. 39.
[72] Stevens, *In Sickness and in Wealth*, pp. 357-358.

able to afford the cost (and at the same time, though they may not have been explicitly aware of this, cover the expenses of the poor), "the 'bankruptcy of the existing system' was evident."[73] The calls for a collective system that would set limits to individual liability gave rise to a long series of attempts at private and public insurance schemes and, lastly and most prominently, the Saskatchewan Hospital Services Plan that came into effect on 1 January 1947. In the pithy words of Gagan and Gagan, "the stage was set for the next iteration of the Canadian public general hospital."[74]

It also was set, although this may not yet have been obvious in 1947 to the parties themselves, for a new and massively increased role for the federal government. Within the next ten years, the country saw the passage of the federal Hospital Insurance and Diagnostic Services Act of 1957, followed another decade later by the federal Medical Care Act of 1966, which came into effect in 1968, practically simultaneously with the centennial of Confederation.

Despite the fundamentally new situation these acts created, the entry of the federal government as a full player onto the healthcare stage did not put an end to the periodic discussions of healthcare reforms and the unceasing struggles over federal and provincial responsibilities and prerogatives that have marked the last few decades

[73] Gagan and Gagan, *For Patients of Moderate Means*, p. 85, citing the Research Committee of the League for Social Reconstruction in *Social Planning for Canada* (Toronto, 1935).
[74] Ibid., p. 96.

of the twentieth century and have until now continued to define the debate during the twenty-first.

As the federal government on the one hand and the provincial governments on the other tried (and still try) to reduce their respective share of the cost while increasing (or at least maintaining) their share of control, there is one effect that is blatantly obvious to all participants and observers of the system and that can only be put down to the increasingly dominant role of public funding: a rapid growth in the degree of bureaucratization. Even the obvious advantages promised by computer technology seem to have done little to make the system more efficient in the Taylorite sense. In Manitoba, for instance, medical reports are only now, in 2014, beginning to be stored and transmitted electronically, and the use by Manitoba Health of two distinct identification numbers for each patient (one of six characters, the other of nine, and both printed on the same card) is a glaring instance of computational ineptitude.

The constitutional principle of provincial control over matters of health (with the exception of such special cases as the registered members of the indigenous population) offers another example of a problem that apparently cannot be resolved at the bureaucratic level. Privacy aside, the prescription drug records of Manitoba patients are automatically accessible to the staff of hospital emergency departments, who thus no longer have to rely on the dubious memories of the patients themselves

or, if such are available, of their families. (It remains to be ascertained if this information is also available to pharmacists other than those who filled a particular prescription.) But there appears to exist no provision at this time for exchanging this information, or of course other medical records, across provincial boundaries.

Beyond a few illustrations taken from daily life, this is not the place to examine the many thorny questions – ranging from fundamental issues of ethics to the countless practicalities of maintaining and transmitting patient records electronically – raised by the massive bureaucratization of the Canadian healthcare system. There can be no doubt, however, that the dominance of public funding requires public accountability, and that the current piecemeal accumulation of bureaucratic practices deriving from at least a century of hospital procedures cries out for review, revision and re-thinking in terms of overall efficacy.

The scope of the present historical survey does not permit the inclusion of parallel developments in the United Kingdom or the United States. Yet the enormous political storms unleashed by the recent introduction of a broader insurance model in the United States (commonly, and often in vilification, called “Obamacare”) should at least be noted. This is not, of course, the first attempt at providing coverage for those most in need. In a previous cycle of healthcare insurance, marked by the introduction of Blue Cross schemes in the 1930s, the effect on the medical system is described even by a sympathetic observer as “the brave new world of medicine” that had

already become "specialized, interventionist, mechanistic, and expensive."[75] A generation later, the introduction of Lyndon B. Johnson's "Medicare" and "Medicaid" as federal health plans for those over 65 years of age and the indigent, respectively, had brought about a vast increase in participation in healthcare, and between 1966 and 1967, the cost per patient had actually doubled within a single decade.[76]

At the end of the twentieth century, in fact, Rosemary Stevens sees hospitals in particular "undergoing a transformation that may prove as profound as the one they experienced between 1870 and 1920"[77] – and this long before the introduction of the Obama reforms! But in Stevens's view, the basic attributes of the U.S. hospital system seem to remain constant over time: "extravagant, visible, flamboyant, exclusive and money-oriented, just as it was at the beginning of the century."[78]

The Invention of Privacy

If the protection of privacy is a non-negotiable principle with respect to patient records, it goes without saying that the inherent structural conflict between privacy and efficiency is notoriously problematic. A generation ago already this complex set of issues was confronted head-on by Wendy Mitchinson and Janice

[75] Stevens, *In Sickness and in Wealth*, p. 190.
[76] Ibid., p. 287.
[77] Ibid., p. 321.
[78] Ibid., p. 355.

Dickin McGinnis in the introduction to their 1988 *Essays in the History of Canadian Medicine.* In discussing the difficult matter of access to patient records, they speak of the "hesitancy of historians, archivists, and medical authorities to come to terms with the question of patient confidentiality."[79]

The process by which the special quality and status of patient records emerged is in itself an interesting topic. In a closer examination of this subject (which would go far beyond the scope of the present thesis), one would presumably explore above all the question whether the recognition of patient confidentiality emerged more or less imperceptibly or if discrete steps could be identified in this process.

The issue of patient records is part of the more general question of personal privacy. There can be little doubt that the concept of privacy is mainly an invention of the late twentieth century. A single example will suffice: in 1882, each patient admitted to the Winnipeg General Hospital was "requested to state his or her name, sex, age, religion, birthplace, residence and disease." All this information was written on cards that were then attached to the head of their hospital beds, and "a daily list containing the records [in the previous clause]" was also posted in the hall so that the various clergymen could see whom they should visit.[80]

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[79] Wendy Mitchinson and Janice Dickin McGinnis (Eds.), *Essays in the History of Canadian Medicine* (The Canadian Social History Series, Toronto: McClelland and Stewart, 1988), p. 11.

[80] Winnipeg General Hospital, *By-Laws of the Winnipeg General Hospital (as amended and passed July 12, 1882)* [printed pamphlet bound with *Report of the Secretary-Treasurer from April 1, 1882, to*

The current position on matters of personal privacy of the various governments in Canada is articulated in a body of legislation that has for the most part appeared during the last quarter of the twentieth century. A first flurry of activity is marked by the federal Human Rights Act of 1977, the Charter of Rights and Freedoms of 1982 and the federal Privacy Act of 1983. With respect to patient confidentiality in particular, most of the individual provinces had by the turn of the century enacted their own privacy legislation, with the Province of Québec, followed by Manitoba, leading the way. In short, the outcome of the process is clear: with the introduction of successive layers of privacy legislation, the special status of patient records has become firmly entrenched.

Just as clearly, the practice of privacy continues to prove perplexing to those working outside healthcare institutions, and the attempts that have already been made to address its practical ramifications through the various personal/health information protection acts of the last four decades also raise archival questions of the greatest complexity and delicacy. Given the fundamental distinction between patient records and the corporate records of a hospital, however, the issue of privacy largely remains beyond the domain of the corporate hospital archives.

December 31, 1883 [...] and subsequent annual reports], p. 14; Health Sciences Centre Archives/Museum, F4; S4.

The Digital Revolution

As all concerned struggle with the principles of privacy with respect to patient records and their implementations, every aspect of these problems is greatly exacerbated by the advent of electronic methods of record-keeping. The locked cabinets and carefully guarded access of earlier store-rooms were suitable for physical records in the form of paper documents. Entirely new locks are required for electronic data, and while the access rules and copying privileges are being developed and implemented, in the everyday world of hospitals and archives alike the process often takes place in reverse order: the low-level technicalities determine the practice irrespective of principles and theory.

Finally, we need to remind ourselves that even the best-kept locking device is subject to failure once a human user enters the scene. A single grand illustration should suffice: luckily, the double-key systems reportedly used for the nuclear weapons of mass destruction by the major world powers seem to have worked remarkably well until now (even though that fact, alas, is no guarantee that they will continue to work). In the realm of mere documents, too, one can safely presume that the locks installed by the National Security Agency of the United States were many, strong and sophisticated – yet they proved no match to the ingenuity and determination of a single human being, Edward Snowden.

The scientific and social revolutions which had created the modern hospital by the turn of the twentieth century in their aggregate "could not help but reproduce fundamental social relationships and values in microcosm."[81] Over the next century, the social and economic revolutions provoked by the extraordinary growth in size, number and scope of North American hospitals took somewhat different courses in Canada and the United States.[82] The progressive bureaucratization of the modern hospital, for instance, is readily observed in both countries, as will be the effects of the digital revolution. But the early introduction of universal healthcare in Canada sets them apart (despite the underlying similarities pointed out by Stevens[83]), and so, perhaps, has the process of rampant reorganization, amalgamation and centralization which has so radically transformed the Canadian hospital scene over the past two decades.

As we have seen, the historical developments of the past century and a half resulted in the emergence of the modern general hospital as the primary facility for medical treatment and care not only of the indigent and incurable but of the entire population. We next examine the realization, at first arising piecemeal and

[81] Rosenberg, *The Care of Strangers*, p. 337.
[82] For the United States, Rosenberg reports 178 hospitals in 1873 and almost 5,000 by 1923 (Rosenberg, *The Care of Strangers*, p. 341); Stevens reports 6,700 "registered hospitals" in 1930, "of which fewer than 3,000 were certified by the ACS" (Stevens, *In Sickness and in Wealth*, p. 118); the survey conducted by the American College of Surgeons at the end of World War I included Canada (Gagan and Gagan, *For Patients of Moderate Means*, p. 62); no comparable statistics are given (or were found) in the standard Canadian works.
[83] Stevens, *In Sickness and in Wealth*, p. 352.

punctuated by long pauses and only later gaining momentum with the foundation of the Association of Canadian Archivists and the rapid growth of a Canadian archival identity, that these records are valuable not only for legal purposes but also as a means of maintaining the identity of the hospital and enhancing its position in the community.

CHAPTER TWO

BUILDING THE CASE FOR HOSPITAL ARCHIVES

The traditional lament about archives that are badly organized, full of gaps and often entirely lacking is not limited to historians. It can also be heard from notoriously hard-nosed hospital administrators, such as the Secretary-Treasurer of the Winnipeg General Hospital writing in his *Report* for 1882 and 1883:[1] "During the past year unceasing efforts have been made to secure the early records of the Hospital, but without avail." Thirty years later, in 1913, in what is said to be the first history of an English-Canadian hospital, we read that "the compilation of this brief history of the Toronto General Hospital has been [...] difficult [because] the hospital records, if there were any, have disappeared [...]."[2] It took another two generations for another Toronto hospital, the Hospital for Sick Children, actually to establish an

[1] *Winnipeg General Hospital, Report of the Secretary-Treasurer from April 1, 1882, to December 31, 1883, with a list of the Life Governors and Annual Subscribers entitled to vote at the Annual General Meeting, February 11, 1884* ([internally dated] January 30, 1884), p. 7; Health Sciences Centre Archives/Museum, F4; S4.

[2] C.K. Clarke, *A History of the Toronto General Hospital: Including an Account of the Medal of the Loyal and Patriotic Society of 1812* (Toronto: W. Briggs, 1913) as cited in Craig, "The Canadian Hospital in History and Archives," p. 52.

archives.[3] Remarkably, it was the hospital's Secretary, E.H. Shuter, who explicitly declared shortly afterwards that it is necessary to "first, make one position [...] responsible for the retention of these precious records" and then prescribed the method for putting this principle into practice: "The basic idea is a single appointment to look after archives, supplemented by volunteer help to get it started."[4] Much at the same time, finally, the administrative archives in Canadian hospitals began to show the influence of similar remarks scattered over a wide range of literature written by medical historians, archivists and hospital officials in the United Kingdom and the United States.

The formation of the Association of Canadian Archivists (ACA) in 1975 and the ACA survey of healthcare archives in 1979 were the opening acts in a rapidly developing series of events that can justifiably be termed "the Canadian Awakening." The stage was set in 1985 when Robin G. Keirstead produced a seminal survey of the relevant literature;[5] though limited to articles dealing with Ontario and British Columbia, Keirstead's lead was quickly followed by a comprehensive annotated bibliography published in *Archivaria* in 1989 by Carl Spadoni and the equally

[3] As confirmed by correspondence with David Wencer, the Archivist, the archives at Toronto's Hospital for Sick Children was established about 1972, roughly coinciding with the preparation of Max Braithwaite's book, *Sick Kids: The Story of the Hospital for Sick Children in Toronto* (Toronto: McClelland and Stewart, 1974).

[4] E.H. Shuter, "Save those Old Pictures," *Hospital Administration in Canada* 20(7), (July-August 1978), p. 31.

[5] See Robin G. Keirstead, "An Archival Investigation of Hospital Records" (unpublished M.A.S. thesis in Archival Studies, University of British Columbia, Vancouver, 1985).

comprehensive update published a few years later, in 1995, by Geoffrey Reaume and Barbara L. Craig.[6]

Since these bibliographies attempted to cover all types of medical archives, they included titles dealing with everything from patient records, persons of note and the associations to which these people and/or institutions belonged, specialization in terms of specific departments (programs and services) or medical conditions, library and museum holdings, acquisitions lists, surveys using medical records, all the way to oral histories, histories of a specific institution, and general histories of medicine and/or nursing. Of the nearly 500 titles surveyed by Spadoni and by Reaume and Craig, fewer than a fifth deal with the structure and operations of an archives.

The vast realm of healthcare archives covers a large number of distinct types. These types group themselves into two clusters which, in effect, constitute the two ends of a spectrum. At the one end we find *patient records* and the records of scientific and clinical *research;* at the other extreme are the *corporate records* of the hospitals. These encompass a broad range of record types, from board minutes, legal contracts, and a variety of fiscal records (where the scale may run from multi-year budget plans down to individual invoices and receipts), all the way to publicity materials, news releases and staged photographs.

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[6] Carl Spadoni, "Medical Archives: An Annotated Bibliography," *Archivaria* 28 (Summer, 1989), pp. 74–119; Geoffrey Reaume and Barbara L. Craig, "Medical Archives: An Update of the Spadoni Bibliography, 1986–1985," *Archivaria* 41 (Spring, 1996), pp. 121-157.

This distinction is inherent in the materials – and this is a matter of fundamental importance – but it is also apparent in the way in which some of these records have been handled and stored. The medical records in the narrowest sense, the patient records, are universally recognized as sensitive and subject to all kinds of moral and legal constraints. The scientific records of medical researchers are only slightly less sensitive and, in the case of clinical studies, often include actual patient records. All these medical records lie outside the scope of the present thesis.

Also clearly beyond the scope of corporate archives in healthcare institutions are three further types of records which are normally treated as confidential even though they are not patient records in the strict sense. The legal, personnel and fiscal records of hospitals are typically held in special repositories under the control of specialized professional officers such as in-house counsel, personnel managers and accountants. The special status of these records becomes obvious in situations where a hospital finds itself in crisis or under attack due to claims or accusations of misconduct or incompetence. A classic instance, as presented in *The Report of the Manitoba Pediatric Cardiac Surgery Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994*, Associate Chief Judge Murray Sinclair

(often referred to as the Sinclair Inquiry),[7] illustrates one model for dealing with the archival aspect of such cases. About twenty years ago, when concerns arose about the performance of a newly appointed specialist in pediatric cardiac surgery at the Health Sciences Centre, questions were also raised about the care or lack thereof with which the surgeon's appointment had been handled, the diffuse responsibility of those in authority, and the manner in which the initial reports of the nurses who witnessed the operations had been brushed aside. Ultimately, the inquest produced almost 50,000 pages of transcript evidence and more than 100,000 pages of documents filed as exhibits. Except for *in camera* testimony, "The evidence and transcripts will be available through the Provincial Archives of Manitoba."[8] The two crucial points in the present context are, first, that at the Archives of Manitoba the records of the Sinclair Inquiry are not part of a Health Sciences Centre fonds but under Government Records; and, second, that not one shred of paper related to this case has found its way into the corporate archives of the Health Sciences Centre, Winnipeg except for the published report of the inquiry.

In the present thesis, therefore, the term 'corporate archives' is used to cover first and foremost the *general records* of the institution. Such records are of interest to the social history of medicine, and any social history dealing with the development

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[7] *The Report of the Manitoba Pediatric Cardiac Surgery Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994, Associate Chief Judge Murray Sinclair* (Winnipeg: Provincial Court of Manitoba, undated), pp. 21-22 [released on 27 November 2000].

[8] Ibid., p. xxvi; another model would see the records disappear into the locked cabinets of legal firms or the court archives.

of either hospitals as institutions or the more general establishment of civic consciousness and pride. These records may also offer a new (or previously overlooked) perspective on labour issues, working conditions, ethnic specializations, etc. Finally, since these administrative records contain the formal policies of the hospital (and often even a record of their development prior to their formal promulgation), they constitute a crucial prerequisite if the patient and legal records are to be fully understood.

Whatever variation may exist in the large and complex healthcare institutions, and whatever problems these institutions may encounter, the sharp and consistent segregation between medical records in the narrow sense and all other records kept in hospitals is fundamental and paramount. In fact, it is rare to find instances where the corporate archives of a Canadian hospital hold records of the medical type (except in cases where the patient information has become part of the corporate record, for instance for publicity reasons or as statistical illustration).

Any attempt to review the Canadian scholarship concerning healthcare archives is faced with two sobering limitations. The first of these is the deplorable fact that the expressed recognition of the value of hospital archives is anecdotal for much of the century (coinciding roughly with the life-span, for instance, of the Winnipeg General Hospital) during which the hospital as an institution underwent

three sets of massive changes. During an initial phase, what had still quite recently been a charitable refuge for the indigent and incurable sick became a medical establishment attracting patients of all socio-economic classes by offering scientific discoveries and methods of treatment. In a second phase, it was gradually transformed from a privately or communally organized institution that increasingly relied on patients who could afford to bear the cost of treatment to subsidize those who could not into a quasi-public body marked by an ever-growing reliance on insurance schemes. In a third phase, finally, it became almost completely dependent on public funding. The second limitation on any such review is the fact that Canadian healthcare institutions were relatively late in recognizing the importance of hospital archives and that the archival literature in Canada is, correspondingly, quite recent when compared to that in the United Kingdom and the United States. A brief overview of the literature from 1912 until the 1980s shows that for the most part these early instances of recognizing the importance of corporate records arise from the practical experience of archivists, administrators and lawyers. Although they are of necessity anecdotal and usually brief, they are typically very much to the point.

In the three decades that have passed since the early days of the "Canadian Awakening," the world of healthcare archives in Canada has undergone further far-reaching changes, which left at least some of them re-arranged almost beyond recognition. First, many hospitals adopted some version of the new approach of the

'Program Management Structure,' which "brought doctors, nurses, allied health professionals and administrators together in teams focused on planning and managing each of the major clinical services."[9] The Health Sciences Centre was the first hospital in Winnipeg to adopt this model, and the new structure, by softening the boundaries between the professions and converting the strictly departmentalized organization – the "disciplinary silos" – into a set of new programs and services, was bound to affect the placement of the archives and the lifecycle of the records. At the same time, or within the following decade, regional healthcare authorities were organized across the country, for instance in Calgary in 1996 and in Winnipeg in 2000.[10] The fact that in many places hospitals were centralized and re-decentralized on what seems like a fairly regular basis obviously added significantly to the complexity of the current archival scene. A third major event was the introduction of privacy and personal health information acts which not only differ from province to province but also influence the acquisition and access to records in the archives from both a national and international standpoint. Add to these the exponential growth in the speed and scope of electronic recordkeeping, and it is obvious that the past twenty years have been a tumultuous time in the management and archiving of medical and administrative records alike.

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[9] Health Sciences Centre, *Healing and Hope: A History of Health Sciences Centre Winnipeg* (Winnipeg: Health Sciences Centre, 2009), p. 210.

[10] Elizabeth Denham, "Dealing with the Records of Closing Hospitals: The Calgary Area Health Authority Plan," *Archivaria* 41 (Spring, 1996), pp. 78-87; Health Sciences Centre, *Healing and Hope*.

The forces and factors sketched above and their effects on individual hospitals as well as the healthcare system as a whole were, of course, not limited to Canada. In fact, Canadian developments usually lagged behind those in the two countries by which Canada has always been profoundly influenced in its political, economic and cultural life, first the United Kingdom and later the United States. We therefore begin with brief summaries of the precursors and models that the Canadian developments found in these two dominant jurisdictions.

The Usual Models: The United Kingdom and the United States

Among the pioneers in the field, pride of place belongs to the librarians. As Carl Spadoni pointed out in his study of the emergence of medical archives, American librarians "were first to recognize the importance of keeping medical papers beyond their clinical and administrative use."[11] As early as 1912, Grace Whiting Myers had argued that "the ideal location of the hospital library should be next to the medical records department and that, if possible, both areas should be supervised by the librarian."[12]

But the substantive issue of medical archives seems to have remained unrecognized in print until the 1940s when the Librarian of the New York Academy of Medicine, Gertrude L. Annan, urged the "the importance of medical archives" and

[11] Carl Spadoni, "The Contribution of Librarianship to Medical Archives," *Bibliotheca Medica Canadiana* 9(1) (1987), pp. 53-66; p. 53.
[12] As cited in Spadoni, "The Contribution of Librarianship," p. 54.

repeated the lament, well known to us, that "too often correspondence, minutes of medical organizations, documents, diaries, announcements and advertisements of seemingly ephemeral interest have been discarded or relegated to musty attics."[13] Nor was Annan easily discouraged, still offering practical advice in 1958 on rescuing records of historical value from a variety of hospital departments; at that time she specifically listed meeting minutes, programs, lectures, awards, correspondence, scrapbooks, blueprints, portraits, illustrations, memorabilia and reference files.[14]

It is clear from a review of the literature that practitioners in the field of medical archives were well aware of the value of preserving these non-medical types of records, but that their knowledge was not widely recognized outside their field, especially by hospital administrators themselves. Commenting on a combination of events that has become all too familiar sixty years later, an editorial note in *The Lancet* in July 1948 reports that "hospitals of every kind [...] are passing out of the care of their guardians into the smooth hands of the regional hospital boards" and goes on to point out that "Hospital records should be carefully preserved, at least until they have been reviewed by an expert [...] Let us not throw away this unique opportunity of service to history."[15]

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[13] Gertrude L. Annan, "Medical Libraries and Medical Histories," *Bulletin of the New York Academy of Medicine* 21 (1945), p. 163; as cited in Spadoni, "The Contribution of Librarianship," p. 54.
[14] Gertrude L. Annan, "Archives in a Medical Library," *Bulletin of the Medical Library Association* 46(3) (1958), pp. 313-319.
[15] [Editorial], "Hospital Records," *The Lancet*, 31 July 1948, p. 188.

A long, careful and straightforward discussion of many types of such records is given in an article written by Charles Newman for an audience of British archivists. Unlike the *Lancet* editorial of 1948, which used the title "Hospital Records," Newman in 1959 entitled his article, "Medical Records." The types of records he reviews cover the gamut from descriptions of disease both physical and mental and statistical records of disease to records of treatment, personal case notes of physicians and surgeons and records of anatomy and research along with medical education records, notes on students and their behaviour and records about midwives and nurses and, finally, corporate records including occupancy rates and financial records as well as the records of the professional associations. Though Newman does not make the distinction between corporate records and patient records explicit, he is definitely aware of it: "These various sorts of records, bills of mortality, notifications and so on, to which in more recent times could be added census returns, concern the history of medical administration almost more than the history of clinical medicine." [16]

Although his second observation is not the focus of the present study, Newman also draws an important distinction between historical records of prominent institutions and those of the ordinary, workaday world of hospitals: [17]

> The hospitals that get written up are the great teaching hospitals and the infirmaries of cities which have grown big, so that their

[16] Charles Newman, "Medical Records," *Archives: The Journal of the British Records Association* 4(21) (Lady Day [*sic*], 1959), p. 6.
[17] Ibid.

> infirmaries have become both important and a subject of local pride and patriotism. But there are plenty of minutes of hospitals and dispensaries which no one had bothered about, let alone the minutes of Boards of Guardians, about the origins and conduct of the old workhouse infirmaries. They were the hospital provision for a large part of the population, even if they did not, at the time, become great or famous, or the subject of any pride or patriotism at all.

On the more general issue of hospital records, official statements were not long in following. In a piece published in the *Lancet* in 1960, the British Records Association deplored the "indiscriminate destruction" provoked by the "proliferation of papers which modern methods of office administration produce." Focusing on "records of value and interest, often of some age," they suggested that records from before 1858 be retained, records from 1858 to 1911 needed to be reviewed, and that for "documents later in date than 1911, the pamphlet *Modern Records, What May we Destroy?* provides, in general, adequate guidance." Remarkably, the article also provides a list of "records to be searched for" which included minute books, annual reports, etc.[18]

Echoing the call of the British Records Association, the British Ministry of Health in 1961 issued formal instructions "for hospital archives" which not only presupposed the existence of such archives but also that of "the Archivist or Medical Records Officer." The official instructions, for instance, provide for salary and

[18] British Records Association, "Preservation of Medical Records: A Memorandum," *The Lancet* 275. no. 7120 (13 February 1960), pp. 379-380.

wages records to be kept for eleven years and accounts of donations for six years "after the money is finally spent," but "heads of departments and the medical staff refuse to accept destruction of certain documents" along these lines, and N.J.M. Kerling, writing in the *Journal of the Society of Archivists* fifteen years later, supported their refusal with many further examples. He also disagreed with the Ministry's presumption about archives staffing: "In most cases no hospital archivist exists and it is the task of those responsible for public archives to prevent wholesale destruction."[19]

By 1977 the concern for the state of hospital records in the United Kingdom had led to a high-level conference on the Preservation of Medical and Public Health Records, but in reporting about this conference in the *Journal of the Society of Archivists,* Pauline Sears and Patricia Allderidge echo Kerling's remarks and comment somewhat despondently that the "system of administrative and historical reviews proposed in the *Grigg Report* was largely ineffective for hospital records, because it presupposed an orderly system of record keeping and a rigorous supervision of records administration which did not exist."[20]

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[19] N.J.M. Kerling, "Hospital Records," *Journal of the Society of Archivists* 5(3) (April 1975), p. 181-183.

[20] Pauline Sears and Patricia Allderidge, "Medical Records Conference," *Journal of the Society of Archivists* 5(8) (October 1977), p. 554. The "Grigg Report" refers to the 1954 Report of the Royal Commission on Departmental Records chaired by Sir James Grigg, which ultimately resulted in the Public Records Act of 1958.

Even where archivists did exist, the problems persisted; as the working group exploring 'Hospital Records post-1834' reported: "Administrators were clearly aware of problems which arise in record keeping, but the dichotomy between the attitude of the archivist and of the administrator became painfully apparent during largely unproductive discussions."[21] (From the perspective of a Canadian hospital archivist it also seems reassuring that British archivists in the early 1980s acknowledged that the items being collected were not limited to textual records but included artifacts as well.)

In the context of the present thesis, the most interesting working group at this conference on the Preservation of Medical and Public Health Records, convened by the Society for the Social History of Medicine, was that examining 'the Legal and General Administrative Framework,' which explicitly argued that "the distinction between clinical and other records should be made clearer."[22]

In preparation for the conference, the Wellcome Institute had conducted a formal survey "into record activity" at "fourteen Regional Health Authorities, seven Area Authorities, fourteen Health Districts, and twelve Special Teaching Hospitals" with a response rate of nearly 100%. The survey showed that most administrators were "genuinely concerned about their records, but lacked the requisite knowledge to

[21] Ibid., p. 555.
[22] Ibid.

deal with them." What they needed (apart from staff and money) was "professional advice, and help in understanding and implementing the statutory provisions which already existed." More generally, the survey revealed "much ignorance and lack of understanding about records."[23]

In the aftermath of the conference and in view of the fact that "many hospitals have records, archives, and old equipment which are discarded because their historical value and significance are not appreciated," the Wellcome Institute established a Contemporary Medical Archives Centre. This went some way towards realizing the commonly held view that there was a need "for a place to present the history and development of hospitals, nursing, public health, and mental health" that would contribute "to national records, education, and social history."[24] However, it was also recognized that "the work of preserving the archives and artefacts of health care seems destined to suffer unduly, as financial support is nearly always weighed against current spending on health care itself."[25]

In the United States meanwhile, a clarion call concerning "Medical Records and History" was issued in 1964 by the Chief, History of Medicine Division, National Library of Medicine. In broad strokes of the brush, John B. Blake identified three

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[23] Ibid.
[24] D. A. Spencer, "A National Museum of Health?" [letter to the Editor], *British Medical Journal* 287(2) (8 October 1983), pp. 1068-1069.
[25] Julia Sheppard, "A National Museum of Health?" [letter to the Editor], *British Medical Journal* 287(3) (12 November 1983), p. 1467.

groups of medical records. He started with *government records (executive, legislative, judicial):* "records of health departments and other branches of the government with primarily a health activity," including hospital departments, sanitary departments, medical licensing boards. He continued with *private institutions*, including the records of associations, societies, and charitable organizations. And he ended with *private papers of individuals*, including "non-medical figures" such as politicians, philanthropists, and sometimes even patients" as well as medical ones ranging from administrators and scientists to teachers and practitioners.[26]

It seems curious that Blake made no reference to hospital archives even though he discussed the practice of medicine, public health, and the education and training of physicians and obviously considered the widest possible institutional context when he defined medical history as "a broad subject" bearing not only on science "but also on medical practice, on economics, on the social structure, on education, and on government."[27]

Blake's call, however, must have fallen on deaf ears, for a few years later the Archivist of Cornell University, Herbert Finch, in reporting on a survey of medical archives in upstate New York, concluded that his "general findings were much as you might expect, that very little source material exists in the area which scholars can use

[26] John B. Blake, "Medical Records and History," *The American Archivist* 27(2) (April 1964), p. 231-233.
[27] Ibid., p. 229.

to write of medical history," and that "we must urge the importance of awareness of historical records in hospitals and local medical societies." [28]

The wide range of potential donors to healthcare archives, on the other hand, is stressed in a paper by a medical librarian, Stuart K. Sammis, who in 1984 provided another rich listing of non-medical records: "institutional management policies, bylaws, annual reports, correspondence, memoranda, operational statistics, construction plans, and other materials."[29] It seems ironic to read in a subsequent paper by the eminent health sciences librarian Irwin H. Pizer that it is archivists, of all the professional groups involved, who "view health records more narrowly, primarily as collections of patient information." He makes the distinction implicitly when he goes on: "But many of us have been faced with the legal need to provide information on the development of hospital and patient care policies or procedures and policies that relate to faculty and staff issues."[30]

On another of the rare occasions that the subject was broached in the literature outside the field of archival studies, library science or history, it came in the form of a ringing declaration issued from the vantage point of "the nation's premier historical

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[28] Herbert Finch, "New York Medical Archives in Upstate Area," *New York State Journal of Medicine* 15 June 1971(1), pp. 1553-1554.
[29] Stuart K. Sammis, "Building an Archives in a Medical Library," *Bulletin of the Medical Library Association* 72(3) (July 1984), p. 271.
[30] Irwin H. Pizer, "Libraries and Archives," *Bulletin of the Medical Library Association* 77(3) (1989), p. 303.

resource of hospital and health care administration" (i.e., the American Hospital Association's Resource Center in Chicago). It was in the pages of a hospital journal, *Hospital Topics*, that Michael P. McCue, the Director, and his co-authors Connie Poole and Eloise C. Foster argued that –

> hospital archives are a necessity for today's hospitals, no matter what size. Hospital archives are integral to the hospital administration process. No hospital can afford to be without archives.[31]

Elaborating on this forcefully stated point, McCue, Poole and Foster suggest that archival records are not only valuable but essential to publicity/outreach and legal purposes. They argue that "ultimately, the archival program should become an integral part of the hospital administration process."[32] They insist that an archival program, once established, should rely on, and be able to count on, "institutional commitment and funding." Indeed, "The hospital's archives should be funded as part of the hospital's annual budget."[33] Their comments were directed at an American model of hospital funding but they certainly raise the question of how such a funding priority might be built into a model predicated on universal healthcare. Is it likely that a system that is seen, from inside and outside alike, as chronically underfunded would tolerate scarce healthcare dollars being given over to an archives?

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[31] Michael P. McCue, Connie Poole and Eloise C. Foster, "Establishing Hospital Archives," *Hospital Topics* 67(5) (September/October 1989), p. 33.
[32] Ibid., p. 35.
[33] Ibid., p. 36.

The most widely cited work on modern healthcare archives is arguably Joan Krizack's 1994 book, *Documentation Planning for the U.S. Health Care System*. In a precursor article published in 1993, the author addressed the issue of "the functions and component institutions of the U.S. health care system" in depth. Writing primarily about the situation in the United States, she pointed out that hospitals are rarely free-standing institutions but typically function as part of conglomerates or holding companies. These linkages and hierarchical structures "complicate the archivist's task by increasing the duplication of information and physically dispersing records."[34]

Indeed, even in Canada the existence of various regional health authorities (or their equivalents) and the complex inter-jurisdictional overlap between provincial, regional and federal authorities complicates the question of who has responsibility for which records. In an ideal world the archivist could rely on "an archives advisory committee, comprising the archivist, records manager, legal counsel, medical records specialist, and appropriate administrators, physicians, and historical researchers" who would jointly develop a strategic plan.[35] In reality, unfortunately, such an assembly of professionals all agreeing on the same approach to the archival program is rare.

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[34] Joan D. Krizack, "Hospital Documentation Planning: The Concept and the Context," *The American Archivist* 56(1) (Winter, 1993), pp. 16, 17.
[35] Ibid., pp. 17-18.

In Canada as well as in the United States, as Krizack notes in exploring these types of interconnection, "hospitals may embark on research projects jointly with universities or corporations, thus affecting the location of project records" and that physicians in teaching hospitals may also be employed by an affiliated medical school. Given the fact, moreover, that a substantial portion of the education and training, and certainly the practicum work, for every type of medical qualification is done at the hospital, the question remains for the archivist: where are the records and who is responsible for them? Finally, another word of wisdom from Krizack: "Archivists must understand the administrative activities and mechanisms peculiar to hospitals, particularly accreditation and regulation, in order to make sense of the records that result from the activities."[36]

From the perspective of hospital archives, it is especially welcome that Krizack drew a sharp distinction between patient files and administrative records. As she put it, "hospital organization is not strictly hierarchical, but is composed of two main components: the administrative component and the clinical or medical component." She argued further that the "administrative/medical dichotomy has also affected the credentials of hospital chief executive officers, which have alternated historically between management and medical degrees."[37] The same pattern can be seen in the case of the Health Sciences Centre and Winnipeg Regional Health

[36] Ibid., pp. 27-28, 32.
[37] Ibid., p. 27.

Authority. From its inception the head of the Winnipeg General Hospital (President/Chief Executive Officer/Chief Operating Officer) had been a physician. This changed in 1973, when the first non-physician was appointed to the position. It was not until 2004 that there was, again, a president who held a medical degree. Following his departure four years later, the head of the institution was once again no longer a physician. Interestingly, the Winnipeg Regional Health Authority has since its inception in the year 2000 had a physician and a nurse as Chief Executive Officer.[38]

The Canadian Awakening

It is striking that around the year 1980 we can observe a burgeoning growth not only in the field of archival scholarship but also in the practical implementation of the new approaches by both the archival community and the hospitals themselves. The high point of this concentration of attention is marked in Canada by three organizational endeavours. Initial surveys undertaken by the Hannah Institute for the History of Medicine and by the ACA 1979 and 1981[39] were followed by a third survey, also funded by the Hannah Institute and conducted by Margaret Dunn, which resulted in the publication of *A Directory of Medical Archives in Ontario* in 1983.

[38] Health Sciences Centre, *Healing and Hope*, pp. 110-112.
[39] Craig, "The Canadian Hospital in History and Archives," pp. 57 ff.

More or less simultaneously, the recently formed Association of Canadian Archivists (ACA) published *Archivaria* 10, a special issue on "Archives and Medicine" entirely dedicated to various aspects of the subject. The editors noted that this marked the "first time that any attempt has been made in Canada to bring together in published form the fruits of a wide range of research in this field."[40]

The 1980 *Archivaria* issue on "Archives and Medicine" presented a set of articles about a new social history of medicine. It did not include articles about Canadian hospital records per se nor, most important, about representative classes of records; but it provided valuable insights into hospitals outside Canada, about types of hospitals (rather than some specific hospital), mental health hospital records, government records, disease-specific hospitals and health/patient records (not corporate records). In pointing to the activities of the Hospital Records Committee of the Association of Canadian Archivists and the Hannah Institute for the History of Medicine, the editors looked forward to "a reasoned and careful assessment of the extent to which the archives of medicine need protection."[41] The effervescence of interest documented by this special issue lasted throughout the following two decades and manifested itself not only in the implementation of new archives in various hospitals but also in the publication of numerous further articles in the field of archival studies (notably by Barbara L. Craig).

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[40] [Gordon Dodds, Peter Bower and Barbara L. Craig], "Archives and Medicine," *Archivaria* 10 (Summer, 1980), p. 3.
[41] Ibid., p. 4.

Much at the same time, the fundamental distinction between patient records and the corporate records of a hospital began to be recognized more widely. It was Betty Lowry in the report on her 'Management Information System' project of 1983 who pointed out explicitly that "all Canadian hospitals employ two basic and distinct management information systems, [...] administrative information; and patient information."[42] Her distinction, however, differs fundamentally from that postulated in the present thesis, since the example she gives is not of patient records but of statistical information about patients: "Administrative systems [...] control and monitor budgets and productivity; and patient information systems [...] identify kinds and numbers of patients treated, where and by whom they are treated etc."[43] Under the perspective of the present thesis, this summary and statistical information could well be part of the corporate archives of a healthcare institution.

In sum, while the perspectives and operational definitions may diverge, by the 1980s we can discern the gradual emergence of a more concrete identification of corporate or institutional (or administrative) records and their distinction from medical or patient records.

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[42] Betty Lowry, "M.I.S. Project: Overview and Framework," *Dimensions in Health Service* (March, 1983), p. 42.
[43] Ibid., p. 43.

The Canadian Baseline Surveys

In the 1980s we also begin to see a growing concern with these issues on the part of some members of the archival community in Canada. Among the Canadian scholars who began to call attention to the neglected status of hospital records in the country, one of the leading figures was Barbara L. Craig.

From 1979 to 1981 Craig spearheaded a survey of hospital archives, which was carried out under the auspices of the Association of Canadian Archivists (ACA).[44] The purpose of the survey was to contact Canadian hospitals to determine how their records were being managed and what inventories of records by type and date were held. Using the *Canadian Hospital Directory* published annually by the Canadian Hospital Association, the team surveyed 740 Canadian hospitals, of which 29% responded. 87% of the respondents provided an inventory showing that, although they had records dating back to their incorporation, fewer than 20% had an archives, "and in those institutions which [had] an archival repository, only slightly more than 50% [had] a hospital-wide policy on records disposition."[45]

Although the survey was sent across the country, the pattern of responses meant that Craig was limited to her home province when she stated that "there [are]

[44] Barbara L. Craig, "The Canadian Hospital in History and Archives," *Archivaria* 21 (Winter, 1985-1986), pp. 52-67.
[45] Ibid., p. 58.

no hospital archivists employed in Ontario."[46] As a consequence, what archives work was done in Ontario hospitals was the exclusive responsibility of volunteers. Chances are high that the same pattern played out across the country.

One of the primary purposes of the ACA survey had been to determine what assistance was needed by the individual institutions. The results were presented at the ACA's annual conference in Montreal in 1980. The following year the Association sent a similar survey to participating hospitals and, in cooperation with the Canadian Hospitals Association, produced a series of three articles, written by Harold Moulds, Sylvia Burkinshaw and Ron MacLeod, respectively, under the general title 'Managing Hospital Heritage' in the journal *Dimensions in Health Service* (1982).[47]

Writing for the reader with little records management or archives experience, Harold Mould stressed another fundamental point: that the establishment of "a records management program and that of operating a corporate archives run hand in hand."[48] Playing into the traditional lifecycle model of records management, which was current at the time, he explained that "the natural offshoots of records schedules are a dormant records centre and an archives." He also anticipated the obvious

[46] Ibid., p. 59.
[47] Ibid., p. 58.
[48] Harold Moulds, "Hospital Archives: Necessity or Frill?" *Dimensions in Health Service* 59 (October, 1982), p. 39.

administrative objections: "Neither the records centre nor the archives need be a large and distinct physical entity. They can be organized as parts of already established departments."[49] It was at about this time that the Ontario Medical Association developed a records management schedule for Ontario hospitals to follow. It was finally updated in about 2006 at the request of the Health Archives Interest Group, who ran both records management and archives programs at the time.[50]

In a second article, Sylvia Burkinshaw wrote more optimistically that "recently, hospitals have been developing an awareness of the importance of gathering archival material." She suggested a number of reasons that may have sparked the interest in archival material, notably "the demolition of old buildings and potential destruction of records, photographs and other items" at the very time when anniversary volumes, often inspired by the centennial of confederation, became fashionable.[51]

The final article in the series, by Ron MacLeod, argued that "what to do with all the records is a critical hospital management decision too often postponed until that fateful day when all storage space is occupied." Instead, in MacLeod's view, "a

[49] Ibid., p. 40.
[50] Personal experience of the writer as Archives Co-ordinator at Bloorview MacMillan Children's Centre, 2003-2006
[51] Sylvia Burkinshaw, "A Look at Kingston General Hospital's Archives," *Dimensions in Health Service* (November, 1982), p. 20.

successful archives should be an integral part of hospital administration, a useable resource nurtured by regular additions controlled by the person assigned the professional responsibility to identify, preserve and make available the hospital's archival resources on an ongoing and efficient basis."[52]

MacLeod suggested a list of things that can be done until the archivist comes: drawing up the archives mandate; surveying all records in the hospital; selecting your archives room; briefly listing all transferred material; noting any special restrictions or conditions of use which the archives must follow. He further called on the person temporarily in charge of the records to draw up "an outline or guide to all the possible sources of records in your hospital." This 'Master Series List' is divided into categories: board of governors; medical advisory board; hospital administration president/director; public relations; finance; personnel; housekeeping/engineering; chaplaincy; medical departments; nursing department; School of Nursing; nursing alumnae/alumni association; hospital auxiliaries; photographs; museum objects. Finally MacLeod observes that "municipal, university or provincial public archives have in the past rendered valuable assistance to fledgling programs. These institutions may be able to professionally preserve, house and service your archives on a contract or deposit arrangement."[53]

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[52] Ron MacLeod, "Waiting for the Archivist: Techniques for Novices," *Dimensions in Health Service* 59 (December, 1982), p. 28.
[53] Ibid., pp. 28, 31.

With the results of the baseline survey of healthcare archives widely disseminated, Craig conducted a parallel survey in 1984, in which she asked provincial, municipal and university archives if they held hospital records. The results indicated that of the fourteen responses received four had jurisdiction over hospital records, seven did not and the remaining three were unclear.[54]

A further survey, this time informal, of a handful of Canadian university archives holding records of this nature was carried out in the mid-1980s. It showed that the archives of the Medical Society of Nova Scotia, for example, had been transferred from Dalhousie University to the Provincial Archives; other university archives reported holding "some ancient records" and "important medical archives" (McGill University), records from the Faculty of Health Sciences, the affiliated teaching hospitals "and other health-care agencies" (McMaster University), and "papers of institutions and associations (but not hospitals)" (University of Toronto). In short, according to Spadoni's report in 1987, this survey showed that universities, too, were not reliable in collecting hospital records.[55]

Craig's conclusion that "the archives of Canadian hospitals exist in limbo" clearly echoes Margaret Dunn's diagnosis, which the latter had arrived at a couple of years earlier (1983). She suggested that the absence of archives is generally due to

[54] Craig, "The Canadian Hospital in History and Archives," p. 59.
[55] Carl Spadoni, "The Contribution of Librarianship to Medical Archives," *Bibliotheca Medica Canadiana* 9(1) (1987), pp. 61-63.

economic considerations, that hospitals do not understand the contribution that their history could make, and that they see the use of the historical record as limited, at best, to public relations. She also cautioned that "unless information about the past is made more relevant to hospitals, it is unlikely that there will be any major shift in management attitudes to institutional archives in the foreseeable future."[56]

Craig further noted that "the literature [...] usually ignores differences between institutions and assigns all records to one of three categories: administrative, financial, or medical."[57] In only one respect did she find the situation to be different: the "literature relating specifically to hospital records deals mainly with state-controlled institutions, particularly psychiatric or mental facilities."[58] In these cases the records have been better maintained, having been turned over to provincial archives. This may well be one reason why, as Samuel Shortt pointed out, "in Canada as elsewhere historical interest has focused on the psychiatric institutions rather than on the general hospital for medicine and surgery."[59] In fact, as Spadoni reported a few years later, the Public Archives of Canada had been acquiring medical archives "of national significance" since 1970 but hospital archives are explicitly excluded. Some provincial archives, too, actively seek out medical archives; in the experience of the Provincial Archives of New Brunswick, however, hospital archives

[56] Craig, "The Canadian Hospital in History and Archives," p. 60.
[57] Ibid., p. 62, note 30.
[58] Ibid., p. 61.
[59] Samual E.D. Shortt, "The New Social History of Medicine: Some Implications for Research," *Archivaria* 10 (Summer, 1980), p. 55.

are singled out as "irksome, involving legal questions as to ownership of records and custody," and in the case of other provincial archives, "the approach is either passive, responsive to individual cases, or consciously neglectful."[60]

In 1983 Margaret Dunn, with funding from the Hannah Institute for the History of Medicine, surveyed various institutions including hospitals and produced the *Directory of Medical Archives in Ontario,* which Craig welcomed as the "first guide to primary resources for medical historical research in Ontario."[61] Dunn's guide covered an impressive range of institutions, from the Public Archives of Canada, the Archives of Ontario, and county and municipal archives to the "records of Educational Institutions, Professional and other Association and Councils, Hospitals, and Religious Communities and Churches."[62]

Dunn found that the records are often widely scattered. For example, Toronto General Hospital records can be found at the hospital, the Metro Central Library, and the University of Toronto. Under these conditions, as she put it, "apart from records under the care of established archives, the holdings of other institutions exist in a foggy limbo – unprotected, vulnerable and easy victims to willful or disinterested

[60] Spadoni, "The Contribution of Librarianship," pp. 64-65.
[61] Barbara L. Craig, "'A Directory of Medical Archives in Ontario', Compiled by Margaret Dunn and Edited by Mary Baldwin [book review]," *Canadian Bulletin of Medical History* 1(2) (1984), p. 101.
[62] Ibid., p. 103.

destruction." In so many cases the records are something that survived "on sufferance, the special project of an interested official or a retired staff member."[63]

Where there is no vocal objection to the destruction of records, and no mandated participation from the archives in any decision to dispose of the records, it is all too easy to get rid of old records in favour of more recent ones. Even in the rare cases where management, in theory, has supported the archives, more often than not this interest was concentrated on antiquarian material. Quaint photographs, aged scrapbooks of unknown provenance, newspaper clippings, "the hospital genealogies in the form of staff and student lists – these are sent to the archives while the unique, substantive, institutional records, often repetitive and usually voluminous, are ignored as too common, too problematical or too lacking in curious value."[64]

With reference to Canada as a whole, Spadoni a few years later echoed the observations of Dunn and of Craig about items of "antiquarian appeal," while "institutional records are rarely considered to be of permanent value." But Spadoni was even-handed in apportioning blame for this neglect: "It has only been in the last fifteen to twenty years that professional archivists in Canada have focused on the need to preserve archives relating to medical history and health care."[65]

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[63] Ibid., pp. 105-106.
[64] Ibid.
[65] Spadoni, "The Contribution of Librarianship," pp. 63-64.

In sum, by the late 1980s the desolate state of corporate archives within healthcare had at last been recognized. As for remedial action, the situation remained bleak – and so did the outlook.

New Scholarship, New Professionalism

In the world of hospital archives, the 1980s mark the end of an early phase which is characterized by an extraordinary diversity in the organization and status of the corporate or administrative archives found in Canadian healthcare institutions. An external factor that evidently played a major role in triggering the end of this early phase was the widespread phenomenon of institutional restructuring, a set of rapid and largely simultaneous changes that most commonly took the form of centralization and amalgamation. At the same time, the striking lack of uniformity or, at least, comparability among Canadian hospital archives and the fluidity of both the archives and of the institutions of which they form part is counterbalanced by a remarkably general development towards a more scholarly and professional view of these archives. This fundamental transition in the world of hospital archives, which might without exaggeration be viewed as amounting to a watershed, seems to owe as much to the new social history of medicine as a paradigm shift in historical scholarship as to the vigorous, and also highly diverse, organizational efforts bracketed by such signal publications as *Archivaria* 10 and *Archivaria* 41 and also, notably, by the long-term effects of the ACA survey of 1979.

Last but by no means least we are also faced with the question whether or not surveys by archival scholars in fact have any power to influence the budget process of a public healthcare institution in Canada. It seems likely that the increased recognition that has, in recent years, been accorded to the role of hospital archives might be due to a more general recognition that we see in other fields of social history. Whatever the reason, we begin to see attempts to argue for the social value and, by implication, for the economic value of hospital archives.

As a key figure on the Canadian archival scene, Barbara L. Craig not only deplored the "inadequate archival care of hospital records" but also stressed that, given their lamentable state, "the history of one of the most significant Canadian social institutions cannot be properly understood."[66] At the time Craig was writing, the matched pair of comprehensive treatises on the emergence of the American hospital system by Charles E. Rosenberg and Rosemary Stevens were still to appear in print, in 1987 and 1989 respectively, but their monumental efforts (Rosenberg's had been "almost two decades" in the writing) were not only part of the emerging tradition of "the new social history of medicine" but no doubt had a significant effect

[66] Barbara L. Craig, "The Canadian Hospital in History and Archives," *Archivaria* 21 (Winter, 1985-1986), pp. 52-53.

in speeding it along, quickly becoming standard works of reference.[67] In other words, Craig was by no means alone in her campaigns, and the seminal work of such scholars as James Connor, David and Rosemary Gagan, William Godfrey and others has since then heralded a new wave of archivally-based hospital historiography.[68] Indeed, their efforts amount to a splendid response to Samuel Shortt's call urging "historians to bring Canadian hospital history into the broad stream of Western historical medical scholarship."[69]

In the meantime Barbara L. Craig had extended the scope of her surveys, examining "the historical development of records and recordkeeping, [...] in individual institutions [and] hospitals" in London (England) and Ontario.[70] She now drew attention, most importantly, to the change of recordkeeping systems over time from bound handwritten volumes to loose-leaf printed forms, and the parallel change in staffing of these areas, which had previously been entirely male-dominated. The broader issues of the mode of their production to which she now turned are directly reflected in the records themselves and in their disposition and ultimate location.

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[67] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
[68] See Chapter 1.
[69] Samuel E.D. Shortt, "The New Social History of Medicine: Some Implications for Research," *Archivaria* 10 (Summer, 1980), p. 55.
[70] Barbara L. Craig, "Hospital Records and Record-Keeping, c. 1850 – c. 1950. Part I: The Development of Records in Hospitals," *Archivaria* 29 (Winter, 1989-1990), p. 57.

In the context of the present study, we note with special interest that until the middle of the nineteenth century "the administrative and medical records in hospitals were always kept separately,"[71] and that "both the administrative and the medical records were retained where they were prepared."[72] Patient records were kept by the practitioner himself while administrative and, especially, fiscal records were the domain of skilled book-keepers.[73] Elaborating on this fundamental distinction, Craig adds that, in time, the keeping of the clinical records, too, became professionalized, and that this pattern was largely complete, with the task firmly in the hands of medical records departments by 1930. This is the pattern still followed today, with 'Health Records' or 'Health Information' set up as an entirely distinct department and recognized to be part of the 'bread & butter' of all Canadian hospitals and, in the age of privacy legislation, heavily controlled and carefully maintained.

In 1996, sixteen years after the first special issue about "Archives and Medicine" in *Archivaria*, the subject was visited again, with Barbara L. Craig once more, as she had been in 1980, the theme editor. In her contribution to the new theme issue she drew special attention to Nancy McCall and Lisa A. Mix's study of research patterns in medical archives, in which they evaluate "the use of archival sources in published research," and to Kathryn McPherson's paper on nursing history, which

[71] Barbara L. Craig, "Hospital Records and Record-Keeping, c. 1850 – c. 1950. Part II: The Development of Record-Keeping in Hospitals," *Archivaria* 30 (Summer 1990), p. 21.
[72] Ibid., p. 24.
[73] Ibid., p. 32.

"reinforces the importance of actively uniting archives with memory."[74] In addition there were articles by Heald on the importance of record-keeping to public health; Batson on insights into the way that the managers of one hospital ordered their records to make them useful; Denham on the Calgary Regional Health Authority, and Tough and Maxwell-Stewart on clinical records. Yet even with this strong representation of 'Medicine and Archives', Craig was still forced to conclude rather pessimistically that "underscoring these articles is the lingering problem posed by the poor representation of archival programmes in medical institutions: these are few in number and their existence can be precarious."[75]

In short, after sixteen years marked by a series of surveys and sustained attempts to educate non-archival and non-historian hospital administrators, the situation had not improved a great deal.

Nurses and their Archives

Interestingly, in the early 1990s there was a brief period when the discussion revolved around thematic hospital archives, specifically nursing. It is unclear why this flurry occurred but it may have been related to the closure of the last remaining

[74] Barbara L. Craig, "'Archives and Medicine' Revisited: Looking Out, Looking In, and Looking Ahead," *Archivaria* 41 (Spring, 1996), p. 42; Nancy McCall and Lisa A. Mix, "Scholarly Returns: Patterns of Research in a Medical Archives," *Archivaria* 41 (Spring, 1996), pp. 158-187; Kathryn McPherson, "Nurses, Archives, and the History of Canadian Health Care," *Archivaria* 41 (Spring, 1996), pp. 108-120.
[75] Craig, "'Archives and Medicine' Revisited," p. 44.

schools of nursing. At the same time it may of course just as easily have been the increased interest from the alumnae/alumni associations as more people began to conduct genealogical searches and came across members of their family who had been trained as nurses. Whatever the reason, David Weinberg observed that, "when a nursing school within a larger hospital closes, the records of that school are in danger of being discarded or left to deteriorate while stored in an unsuitable location."[76] Craig, too, deplored the scattered nature of nursing archives, the demise of alumnae/alumni associations, and the "gap between what may be desirable and what can be realistically achieved" presented some real challenges to Canadian nurses who are trying to build the archives of Canadian nursing.[77] At the same time, the issues identified in the case of nursing archives may suggest some of the problems inherent in healthcare archives in general.

According to Craig, theme archives are unusual, and "the practical steps in establishing a home for a theme collection [...] are difficult indeed."[78] For such an approach, public archives tend to be the most obvious choice, usually at the municipal or provincial level, as was the case with the Toronto General Hospital School of Nursing Alumni Association, which donated their records to the City of Toronto in 2003. The records of the School of Nursing remain with University

[76] David M. Weinberg, "Documenting Nursing and Health Care History in the mid-Atlantic Region," *Bulletin of the Medical Library Association* 81(1) (January, 1993), p. 30.
[77] Barbara L. Craig, "Memories and the Memorial: Developing and Managing Nursing Archives in Canada," *Canadian Bulletin of Medical History* 11(1) (1994), p. 241.
[78] Ibid., p. 242.

Health Network.[79] In many cases, in fact, "health care institutions such as hospitals, contemplating the formal establishment of a memorial function, should consider operating a consolidated archives, museum, and historical library, perhaps under the rubric of a 'heritage centre'."[80]

Craig called attention to the fact that much of nursing history is preserved in other places, for instance in municipal and provincial archives, where nursing records are part of government records or hospital records that have found their way to these public institutions. Clearly, "a consolidated 'guide' to nursing historical materials already deposited in institutions is a priority."[81] Only in this way would it be possible to "coordinate existing knowledge about nursing history and the published product would provide a clear focus on nursing archives despite their scattered location."[82] In fact, her suggestion was followed with *A Guide to Nursing Historical Materials in Ontario* (1994), *A Directory of Nursing Archival Resources in Alberta* (1996), and *A Catalogue of Nursing Historical Photographs in Manitoba* (1996). However, there is no comprehensive, searchable guide. What would be interesting would be something similar to "the Center for the Study of the History of Nursing [which] was established at the University of Pennsylvania to collect records documenting the nursing

[79] Ani Orchanien-Cheff, Archivist, University Health Network, Toronto, and Paul Gardiner, Archivist, City of Toronto Archives, personal communication, 2011.
[80] Craig, "Memories," p. 244.
[81] Ibid.
[82] Ibid., p. 245.

experience."[83] The closest approximation to be found in Canada, it appears, are the holdings of the Canadian Museum of History (formerly the Canadian Museum of Civilization) in Gatineau with its comprehensive collection of uniforms, caps and pins.

When all the obvious papers and objects have been archived, finally, archivists are also responsible for going beyond the materials at hand. As Craig suggests, "in addition to creating a 'guide' and to undertaking a systematic program to collect oral evidence, it is also important to seek out documentation that has not been archived and ensure that it is deposited in an appropriate institution."[84]

Towards Implementation

The copious and important writings of Craig and others certainly spurred on a great deal of activity in the realm of healthcare archives in Canada (as presumably did those of her counterparts in Great Britain and the United States, illustrated by the foundation of the Wellcome Institute). But even as recently as 2003, the fundamental distinction between patient records on the one hand and corporate records on the other, still had not fully sunk in.

[83] Weinberg, "Documenting Nursing," p. 29.
[84] Craig, "Memories," p. 245.

This is evident in the booklet *Medical Archives*, published by the Association of Canadian Archivists (ACA) in 2003. In keeping with the new archival professionalism and social history scholarship, this booklet marks another milestone in the development of non-medical archives. It is remarkable for being almost entirely devoted (despite its title) to 'Administrative records' and 'Operational records'. Above all, it contains a commendably explicit statement of the distinction between patient and corporate records. It is however also remarkable that in a booklet of 21 pages, which devotes only a single paragraph (on pp. 7-8) to patient records, all the photographs (bar one) are of patients. There are no photographs of ambulances, empty operating rooms, student nurses in their uniforms at graduation, or equipment.

Ten years after the Dunn survey of medical archives in Ontario, Craig conducted a survey of historians of medicine and records of healthcare facilities. In this more focused study she proposed a "comprehensive tool or suite of tools to assist researchers in locating history of medicine sources."[85] In her 'Report and Analysis of a Survey, 1995-1996,' she argues that "the field is unevenly served by information about these sources – what they are, where they are located, what they contain, and what restrictions exist on their use." Reminding us that "Thematic guides to sources […] emerged [in the 1980s and 1990s] partly in response to the lack of general

[85] Barbara L. Craig, "What Research Tools do Historians of Canadian Medicine Currently Use? What do they Need and Want for the Future? Report and Analysis of a Survey, 1995-1996," *Canadian Bulletin of Medical History* 14 (1997), p. 289.

information about archives holdings," she concludes, however, that "There is no first point of contact nor process linking those who have knowledge of relevant resources for the historical exploration of health and medicine in Canada."[86] In a final section of her survey she "asked custodians to provide information about the extent and accessibility of their holdings of materials pertinent to medicine and health care."[87] (The results of the second half of the questionnaire, according to Craig, have not appeared in print due to funding cuts.[88])

With the advent of 'Access to Memory', the free cataloguing system of the International Council on Archives (formerly ICA-AtoM, now simply AtoM), those institutions that have records that would be of use for the history of medicine are now more easily accessible than they have been since the demise of the Union List of Manuscript Collections (which according to Craig was last updated in 1982) and the electronic successor service of Archives Canada (CAIN).

Not surprisingly, a great many insights emerged through the various surveys, in Canada conducted primarily by Barbara L. Craig. In addition to some of the more general conclusions discussed in the preceding section, we also need to pay attention to her views on some of the more practical issues resulting from her theoretical work. These views can be found most succinctly in her review in the spring 1997 issue of

[86] Ibid., pp. 289, 290-291.
[87] Ibid., p. 293.
[88] Barbara L. Craig, personal communication, 2013.

Archivaria of two books which were written "by archivists involved in medical archives."[89]

The simultaneous appearance of these two books – *Designing Archival Programs to Advance Knowledge in the Health Fields* by Nancy McCall and Lisa A. Mix and *Documentation Planning for the U.S. Health Care System* by Joan Krizack – was clearly at least in part a response to the ferment in healthcare. (Note that Craig's review also covers a third book, *Hospital Patient Care Files: A Guide to their Retention and Disposal* by Maxwell-Stewart, which deals exclusively with patient records.) Craig has high praise for *Designing Archival Programs to Advance Knowledge in the Health Fields* by Nancy McCall and Lisa A. Mix, a work that "covers all aspects of medical archives management" with the goal of being "both a catalyst and a guide in accomplishing a new alignment for archives in medical centers."[90] She notes with evident approval that –

> it is the integration of the management of current records, historical records, personal papers, and museum objects – often an important part of a historical unit in a health-care setting – that makes the volume unusual and, in the end, very useful, because it acknowledges a reality of medical archives life.[91]

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[89] Barbara L. Craig, "Medical Archives: Answers ... and Questions [book review]," *Archivaria* 43 (Spring, 1997), p. 176.
[90] Ibid., pp. 176, 177.
[91] Ibid., pp. 177-178.

In her discussion of *Documentation Planning for the U.S. Health Care System* by Joan Krizack, Craig focuses on "strategic appraisal as a method for shaping the accumulation of useful archives" in the context of a healthcare system of great complexity (types of facilities that deliver healthcare; health agencies and foundations; biomedical research facilities; educational institutions and programs; professional and voluntary association; and health industries). Craig notes that "the volume was clearly motivated by the problem of handling duplicated information and by an acute awareness that institutions are part of a network." She is forced to conclude that neither of the medical archives discussed as examples in these books are as robust as they themselves might indicate or as the authors would want them to be. More generally, Craig is led to acknowledge that "these remarkable and important volumes may demonstrate, paradoxically, that archives are on the margins, neither central to the enterprise of medical history nor central to the accountable records practices in medical institutions."[92]

In a groundbreaking paper on the demography of archivists, published in 2000, Craig herself points out that in 1998 only two of a total population of 302 archivists in Canada were employed by a hospital/medical institution while, in contrast, no fewer than 200 were on the staff of public or university archives; while

[92] Ibid., pp. 175-176, 179.

even in the sectors which notoriously face a struggle for funding, namely museums or galleries, there were eight archivists.[93]

The additional challenges posed by healthcare restructuring were outlined in 1999 by Carolyn Heald, then Senior Archivist, Health/Social Portfolio at the Archives of Ontario. She saw the key problem in the fact that "generally there is no one designated to make decisions about what records must be kept and what records can be destroyed." From her perspective as an archivist, she further identified a central paradox in records management for hospitals: "even though health care is a provincial responsibility, that does not mean the provincial archives has any authority to tell public hospitals what to do." Yet "most hospitals do not have records management programs that take into consideration their administrative records."[94] (Similar concerns about the seemingly haphazard collection principles were discussed by Spadoni and cited in detail earlier in our discussion.)

On the general topic of hospital archives in Canada, an urgent call to action was issued by Robin G. Keirstead in an article in *Dimensions in Health Service* in 1988. He observed that even after the ACA survey and the attempts of the early 1980s to establish hospital archives, "most hospitals continue[d] to pay little practical

[93] Barbara L. Craig, "A Look at a Bigger Picture: The Demographic Profile of Archivists in Canada Based on a National Survey," *Archivaria* 49 (2000), p. 29.
[94] Carolyn Heald, "Challenges Posed by Health Care Restructuring in Ontario," *Canadian Bulletin of Medical History* 16 (1999), pp. 147-149, 153.

attention to the retention and use of archives." He suggested that archival activity was simply not a high priority for those charged with delivering high quality healthcare – even though the records in a hospital archives document the origins of a hospital as a legal (and corporate) entity in addition to its functional development over time. In providing details of specific personalities, places, and events associated with the hospital, the archival collection represented a corporate memory that "can be used [...] effectively within the institution to the potential benefit of both hospital staff and members of the community." Keirstead concluded by positing, at the very least, "a basic program which ensures that records of archival value are systematically identified, preserved, and made available for research and reference." [95]

Unlike some earlier archival scholars, and like more generalist historians, Keirstead tackled the issue of the "complex array of documents referred to under the broad heading of health records" and proposed to extend the scope of the archives proper to reach into the previously closed realm of patient records; he added that "in most hospitals, patient [files] remain the responsibility of the health records department long after they have been closed." Instead, he recommended that a "representative sample of current patient files should be considered for archival preservation, [and that] samples of other kinds of medical documentation" may also

[95] Robin G. Keirstead, "Hospital Archives Revisited: History at Work," *Dimensions in Health Service* 65(4) (May, 1988), p. 21-23.

deserve to be preserved.[96] Provocative in its own right, this article pre-dates most of the Personal Health Information legislation.

Keirstead's brief but challenging article of 1988 and his University of British Columbia Master's thesis in Archival Studies (following a History M.A. from Queen's) mark a high point in the emergence of the new archival professionalism and, at the same time, of the new social history of medicine that undoubtedly played a significant role in bringing it about.

The studies we have reviewed demonstrate the varied state of archives in hospitals across the country. As indicated both in the theoretical literature and by the many individual cases on which they are based, it seems evident that a higher intrinsic value needs to be attributed to the historical collections of these institutions. They are fundamental when it comes to supporting the corporate identity of the institution and at the same time an invaluable record of the social history (as well as the political and economic histories drawn out by previous generations of historians) of Canadian healthcare facilities. Finally, they illustrate the gradual recognition, long before the arrival of privacy legislation, of the fundamental distinction between patient records and administrative records and the corresponding entrenchment, gradual and slow as it may be, of this distinction in the archival practice of Canadian healthcare institutions.

[96] Ibid.

The changes that can be observed in the world of Canadian hospital archives tend to be incremental, and larger shifts in emphasis are rare. At the present time, however, we may be witnessing an important change, brought about in the context of the new social history of medicine, in the gradual professionalization in the field of archival studies. This process is likely to continue and, it seems, to accelerate under the double impetus of an increasing awareness on the part of hospital administrators and those who determine the public funding of healthcare institutions of access and privacy legislation and, at the same time, of the digital records revolution.

CHAPTER THREE

SELECTED HOSPITAL ARCHIVES: CASE STUDIES

Before turning to the 2013 survey and a discussion of its findings, we present selected case studies illustrating the state of hospital archives which, though hardly representative in any technical sense of that term, are intended to complement the picture drawn by William Godfrey in his account of the archives at the Moncton General Hospital (discussed in Chapter 1) and thereby offer a sense of the range of archival situations found in Canada at the present time.

The first two are relatively brief and based entirely on published sources. They contrast the archives of an individual (or "stand-alone") hospital, the Kingston General Hospital (even though Kingston, Ontario of course also boasts another large healthcare institution, the Hôtel-Dieu, which now provides ambulatory care exclusively[1]) with the recent history of the archives at the several hospitals in the Calgary metropolitan conurbation that underwent large-scale reorganization, mainly

[1] Canadian Healthcare Association, *Guide to Canadian Healthcare Facilities* (Ottawa: Canadian Hospital Association, 2013).

by amalgamation, during the last decade of the twentieth century and once more in the first decade of the twenty-first.

In the third case study we present an overview of the archival situation at the Health Sciences Centre, Winnipeg, concentrating on the fundamental change in status that its predecessor institution, the Winnipeg General Hospital, experienced in 1973. In exploring the major consequences of this change, some attention also needs to be paid to the archival effects of the partial amalgamation that the successor institution has undergone over the past two decades. Although this third case study is, of course, also far from exhaustive, it is not only more comprehensive than the earlier two but also represents a different perspective, being based almost entirely on primary, unpublished sources.[2]

Kingston General Hospital

Founded as a charitable hospital in 1833, Kingston General Hospital presents itself as "the third, purpose-built, public general hospital in Canada" and "the oldest still operating as part of a modern hospital;" it also boasts "a complex of limestone hospital buildings of classically inspired design" that led to its recognition as a National Historic Site.[3] Affiliated with Queen's University, it has also long been a

[2] I have been the Archivist at the Health Sciences Centre Archives/Museum since 2010.
[3] Historic Sites and Monuments Board of Canada, Minutes, November 1985 and November 1989, Kingston General Hospital National Historic Site; see http://www.historicplaces.ca/en/rep-reg/place-lieu.aspx?id=4218 (accessed summer 2014).

leading healthcare institution. In 1894, for example, the design of its new maternity pavilion "responded directly to the use of isolation, asepsis and antisepsis" as championed by Semmelweis, Pasteur and Lister.[4]

The hospital archives, too, was begun relatively early, in 1967, in conjunction with the Board of Governors authorizing the preparation of a "commissioned history" and, once this work was duly published,[5] appointing a "Board of Governors Archives Committee," which had representation from a remarkably diverse and inclusive set of constituencies: doctors, nursing alumnae, the Women's Aid Society, the hospital staff, and even the Archivist in charge of the Queen's University Archives.[6]

If the Kingston General Hospital Nurses Alumnae Association, in particular, played a key role in the development of the hospital archives over the next 40 years (analogous to that of the Winnipeg General Hospital School of Nursing Alumnae, to be discussed below), it culminated in the deposition in several phases between 1980 and 1997 of their textual records "and other material" reaching back to 1888.[7] The Nurses Alumnae also produced a separate history of the Nursing School, in two

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[4] Ibid.; cf. also Chapter 1, above.
[5] Margaret Angus, *Kingston General Hospital: A Social and Institutional History* (Kingston and Montreal: McGill-Queen's University Press for Kingston General Hospital, 1973); a second volume appeared many years later, this time published by the hospital itself: Margaret Angus, *Kingston General Hospital: A Social and Institutional History, volume II: 1965-1992* (Kingston: Kingston General Hospital, 1994).
[6] Sylvia Burkinshaw, "A Look at Kingston General Hospital's Archives," *Dimensions in Health Service* (November, 1982), p. 20.
[7] Queen's University Archives, Kingston General Hospital Archives, fonds KGH 5999-950 – Kingston General Hospital Nurses Alumnae Association fonds.

editions, first as a "tercentennary project" in 1973 and later in a revised edition as a "millennium project."[8] Nor were they the only ones to acknowledge their history and have it recognized by the wider institution: the hospital itself published a centennial history of the Women's Aid Society in 2005.[9]

The corporate activists aside, another major player in the development of the archives of the Kingston General Hospital is clearly James A. Low, from 1965 to 1985 Head of Obstetrics and Gynecology at Queen's University and since then the founder and executive director of the University's Museum of Health Care, the only such museum in all of Canada. Most important in the archival context, Low later wrote a foundational article about the development of a records management and archival program at the Kingston General Hospital, in which he identified "three essential requirements" for such a program: [10]

- institutional commitment;
- a professional staff;
- a secure location.

As it happened, Kingston General Hospital met these requirements because the proposed program had the endorsement of the President and the Board of Directors;

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[8] Katherine Connell Crothers, *With Tender Loving Care: A Short Story of the Kingston General Hospital Nursing School* (Kingston, 1973; revised edition, 1999).
[9] Ellen Barton, *Purpose and Passion: Kingston General Hospital Auxiliary 1905-2005* (Kingston: Kingston General Hospital, 2005).
[10] James A. Low, "Administrative Records Management and Archival Program: The Kingston Experience," *Canadian Bulletin of Medical History* 18 (2001), p. 383.

the proponents had succeeded in securing the appointment of a hospital archivist; and by 1979 they had been able to reach an agreement with Queen's University to maintain the archives within the Queen's University Archives.[11] Even then, however, it was not until the early 1990s that "the development of a formal administrative records management and archival program began," with an archival assistant position added in 1999.[12]

Low made a case for the permanence of the records of the individual healthcare facilities both for their own sake and for that of the historians of health. The careful management of hospital records, including the establishment of archives, he argued, are essential to "ensure that health care institutions maintain control of their administrative records and that the primary records for the historian of health care are not lost." Moreover, the ongoing restructuring of the healthcare system highlights the necessity to preserve these records. Without this care we risk losing many the records of historically significant healthcare facilities as they are closed and/or amalgamated.[13]

Low actually went further in defining five categories of administrative unit that needed to be recognized and kept distinct:

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[11] Sylvia Burkinshaw, "A Look at Kingston General Hospital's Archives," *Dimensions in Health Service* (November, 1982), p. 21.
[12] Low, "Administrative Records Management and Archival Program," pp. 381, 382-383.
[13] Ibid.

- board of directors;
- hospital administration;
- professional administration;
- clinical services; and,
- volunteer organizations.

In stressing the importance of "the major developments in medicine and the care of the patient," he was not concerned with patient records but with clinical records in a broader sense: "These primary records are necessary to preserve evidence of these activities for current and future generations." He also attended to practical details such as the regularly scheduled pruning of files in a system of records management that would lead to "more relevant administrative files with reduced storage and space requirements," thereby "contributing to operational efficiency." Above all, he stressed, "Administrative records management and archival programs are important to the hospital administration. These programs assure that records of administrative, legal, fiscal, and evidential value are retained."[14]

In retrospect, Low, the practitioner of both medicine and of archival and museum preservation, had a very clear view of all the issues at stake. His position was modest but firm: [15]

[14] Ibid., pp. 384, 387.
[15] Ibid., p. 388.

> Ours is a small beginning in relation to the large records management problem of the health care institutions in Canada. The experience in Kingston has demonstrated that the development of a records management program in an active treatment hospital is labour intensive and requires a professional staff. There is an urgent need for a greater commitment if the records management requirements of Canadian health care institutions are to be met.

He clearly has both the practical requirements of the hospital and the intellectual concerns of the historian in mind when he warns that "much of the history of health care in Canada will be lost unless similar initiatives to ensure the preservation of primary records of Canadian health care institutions are undertaken."[16]

The Calgary Regional Health Authority and its Precursors

The most comprehensive account for any set of Canadian healthcare institutions that goes beyond the limits of an individual hospital to cover a large metropolitan area with its specific complexities is offered by three seminal articles about hospital archives in Calgary. In 1979, at the height of the early phase of archival advocacy and survey activities, Janice Dickin McGinnis had been "commissioned to write a short social history of the Baker Memorial Sanatorium" and "was invited to take full advantage of the institution's records and accumulated

[16] James A. Low, "Administrative Records Management and Archival Program: The Kingston Experience," *Canadian Bulletin of Medical History* 18 (2001), p. 381.

memorabilia."[17] What she found was not so much an archives but an exceptionally "copious and very complete" collection of historical records that seems to have left her in shock: "There were no shelf-lists, there were no finding aids, no accession numbers. Items were not even in order." It appears likely that the records of the Sanatorium were preserved largely because there was enough space to store them. Elsewhere in Calgary and across the country, at the same time, it was "usually in the name of more efficient use of space" that hospital records were being destroyed, and "at an alarming rate." Dickin McGinnis cited the example of the Calgary General Hospital, which, though "a much older institution than the San," when it came to depositing papers in the Glenbow Archives, "has really very little to give."[18]

In the context of the present study, Dickin McGinnis deserves special credit for her explicit acknowledgment that "the main body of records of the Baker Memorial Sanatorium divide into two classes – administrative and medical."[19] As a historian in training who had already published "the first historical overview of the [influenza] pandemic in Canada,"[20] Dickin McGinnis made a strategic decision to

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[17] Janice P. Dickin McGinnis, "Records of Tuberculosis in Calgary," *Archivaria* 10 (Summer, 1980), p. 174; her historical account was published as "The White Plague in Calgary: Sanatorium Care in Southern Alberta," *Alberta History* 28:1-13, Autumn 1980.
[18] Ibid., pp. 175-176.
[19] Ibid., p. 182.
[20] See Esyllt W. Jones, *Influenza 1918: Disease, Death and Struggle in Winnipeg* (Studies in Gender and History, Toronto: University of Toronto Press, 2007), p. 6; see also Janice P. Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919," *Canadian Historical Association Historical Papers, 1977*, pp. 121-140, reprinted in Samuel E.D. Shortt (Ed.), *Medicine in Canadian Society: Historical Perspectives* (Montreal and Kingston: McGill-Queen's University Press, 1981), pp. 447-477.

spend "very little time" with the administrative records in the narrow sense because it would "take too much digging for too little return [...], it was easier to track down and interview [...] staff," especially since she was "not interested in writing a comprehensive history of the institution." Instead, she found that "the medical records of the Baker Memorial Sanatorium contain numerous collections of reports via which medical staff tried to maintain order in the treatment of patients" – and concluded that these, in fact, "are really just a special type of administrative record."[21]

In reviewing the unusual wealth of records of the Baker Memorial Sanatorium, where "gaps in the major collections are rare," Dickin McGinnis (who is both a historian and a legal scholar) sums up by calling for the appointment of an archivist "in order to make the records readily available to those who may wish to use them now and to save them for those who may wish to in the future." As her conclusion asserts in a tone of righteous resignation: [22]

> Institutions do not destroy their history [...] through any sort of perversity. They simply do not think that anyone would be interested. Until recently they were, unfortunately, only too right in this conviction.

The history of the Calgary General Hospital which Janice Dickin McGinnis mentioned as being written at the same time by a fellow Calgary historian, Darlene J.

[21] Dickin McGinnis, "Records of Tuberculosis in Calgary," p. 182.
[22] Ibid., p. 188.

Zdunich, apparently was not completed. Sixteen years later Elizabeth Denham (who holds a University of British Columbia Master's degree in Archival Studies) found herself dealing with the records of the Calgary General Hospital, which had evidently not been transferred to the Glenbow, when the reorganization of Alberta's healthcare system and the establishment of regional health authorities led to questions concerning the management of current and historical records.

Traditionally, records in general and artifacts had not been managed by an effective records management program (for administrative records) but health records (or patient records) typically were managed well. In this case, the impending demise of the Calgary General Hospital and the transfer of authority and responsibility to the new regional board resulted in a plan of action jointly devised by the newly formed Calgary Regional Health Authority and the senior administration of the hospital about to be closed. Denham believes that "this combination of administrative and board support for the archival project gave it a high profile and contributed in a major way to its success." The first step in the process was the appointment by the Calgary General Hospital Board of an archivist "to locate and inventory historical artifacts and assist in defining how the hospital could be commemorated after closure." There would be no need to deal with the personal records of patients, in the judgment of all concerned, "because existing, well-established medical records programmes and

legislated retention periods provided guidance for the management of patient charts."[23]

Recognizing that these "legacy issues were regional in nature, not specific to the closing institutions," the Calgary Regional Health Authority called on "nursing alumnae organizations, medical staff, museum committees, art committees, and volunteer associations" at all the hospitals being closed to take an active part in "collecting and maintaining [their] historical collections." In short, as Denham points out, "The Board recognized that preservation and access to the archives was important for staff morale and serves as a sign of continuity and care."[24]

Interestingly, there was an unofficial follow-up article three years later by Donna Kynaston, then at the Calgary Regional Health Authority (and now Head of Records and Archives at the World Health Organization in Geneva). She found that "the application of Freedom of Information and Protection of Privacy, or FOIPP, legislation to Alberta's healthcare sector in October 1998 created awareness of the need to identify, appraise, maintain, and provide access to both administrative and medical hospital records of long term value."[25]

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[23] Elizabeth Denham, "Dealing with the Records of Closing Hospitals: The Calgary Area Health Authority Plan," *Archivaria* 41 (Spring, 1996), pp. 80-81.
[24] Ibid., pp. 81-82, 85.
[25] Donna Kynaston, "Establishing Standards for Health Care Archives: A Case Study of the Calgary Regional Health Authority," *Canadian Bulletin of Medical History* 16(1) (1999), pp. 156-157.

Kynaston concluded that "it was possible to establish these programs and to begin to introduce the standards necessary for their operation for two reasons." One was support of the Board and senior management, and the other, the introduction of provincial privacy legislation. A third reason may presumably be seen in the fact that an active archival program had already been put into operation in the Calgary Regional Health Authority in the mid-1990s "simply with the consolidation and archival management of records from Calgary's three closing hospitals."[26] This had been in response to a desire by "members of the Boards of the Calgary General and the Holy Cross Hospitals to establish 'legacy' committees [...] to identify issues relating to the preservation of an historical legacy for these institutions."[27]

The establishment in the summer of 1997 of their Archives and Records Management Program by the Calgary Regional Health Authority in fact amounted to a major legacy by itself. As Kynaston pointed out, the Calgary Regional Health Authority was the only regional health authority in Alberta to have managed to set up such a program.[28] Kynaston further reports that "information about the CRHA's Archives, Records Management and Information and Privacy programs can be found within the CRHA's website."[29] However, as the Calgary Regional Health Authority became part of Alberta Health Services in a further round of centalization in 2008,

[26] Ibid.
[27] Denham, "Dealing with the Records of Closing Hospitals," p. 80.
[28] Kynaston, "Establishing Standards for Health Care Archives," p. 157, 160.
[29] Ibid., note 2.

the original link now connects directly to the Alberta Health Services website.[30] According to the Archives Society of Alberta, the Alberta Health Services – Calgary Archives site now appears to be run from the main Alberta Health Services Office in Calgary.[31] In sum, it appears that the legacy continues, but this is a rare success story. The general case, in Denham's assessment, is more sombre:

> the preservation of health care archives, and the establishment of records management programmes, is too often at the whim or passion of a few individuals (a dedicated Board member, an interest group for the history of medicine, a hospital volunteer group, or an informed administrator).[32]

Winnipeg General Hospital and the Health Sciences Centre, Winnipeg

Shortly after the Winnipeg General Hospital ceased to exist in 1973, to be transformed and absorbed into the newly created Health Sciences Centre, Winnipeg, a truckload or two of archival material was delivered to the Provincial Archives of Manitoba (as it then was). More than a generation later, what may well have been thought to constitute the complete surviving body of records of the Winnipeg General Hospital still remains unsorted and only loosely processed, not only because of special restrictions that were initially placed on the deposit[33] but, more important,

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[30] http://www.albertahealthservices.ca/about.asp (accessed fall 2012).
[31] http://asalive.archivesalberta.org:8080/access/repos/rep/display/crha) (accessed fall 2012).
[32] Denham, "Dealing with the Records of Closing Hospitals," p. 87.
[33] Correspondence between Barry Hyman, Assistant Provincial Archivist, and Beatrice Fines of the Public Relations Department at the Health Sciences Centre and Peter Swerhone, President, Health Sciences Centre, Winnipeg, 13 September 1976 – 22 April 1982, Health Sciences Centre Archives/Museum, current correspondence file.

because the Archives of Manitoba (as it now is) has to give priority to public records. The legal status of the Winnipeg General Hospital, as this instance shows, had remained that of a private foundation for the entire one hundred years of its history.

The crucial aspect of this tale bears repeating: the Winnipeg General Hospital was at all times a private institution, while its successor, the Health Sciences Centre, Winnipeg, is a public one. This point was important enough in 1940 to be included in the Address of the President, W.M. Neal, who could not have made it more explicit than in the following statement:[34]

> The Winnipeg General Hospital is not a public institution. [...] The Winnipeg General Hospital is a private institution, governed by a committee of citizens of this community since its inception, and operated […] as a public service in the interests of humanity.

In this context, then, it appears that the annual *Reports and Accounts* that were published under a variety of titles from from 1883 until 1972 were not intended merely for the members of the Board of Trustees or, perhaps, for those members of City Council or even the Legislature who might be inclined to argue for public subsidies despite the private status of the hospital. Instead, it seems to have been their primary purpose to solicit contributions from the general public.

[34] Winnipeg General Hospital, *Reports and Accounts [for] 1940*, p. 19.

A Tale of Two Archives

Ironically, the records of the Winnipeg General Hospital have not yet yielded much information about the efforts that may have been made from time to time at archival preservation. There can be no doubt, on the other hand, that the hospital must at all times have produced a mass of records of every type. The earliest surviving set of by-laws already, issued in 1882, refers on no fewer than seven occasions to situations where a written record had to be created: the patient's personal data (including religion and birthplace) to be "properly entered upon the usual card" (28); "a daily list of the patients in the hospital" (29); "the names of all visitors to be entered in a book" (30); the Medical Board "shall from time to time make out a dietary [*sic*] for the patients" (33); "Patients will be admitted solely on the written authority of an ordinary member of the Medical Board" (34); "A case book shall be kept [by the attending physician]" (35); "the House-Surgeon shall "keep such books in regard to the cases" (47). [35] But we need look no further than the annual volume of reports running for almost a century to realize that only "high-level" records such as the printed *Reports and Accounts* themselves, the minutes of the Board and the senior committees, plus some construction and financial records, were likely to be kept for more than their active period.

[35] Winnipeg General Hospital, *By-Laws of the Winnipeg General Hospital (as amended and passed July 12, 1882)* [printed pamphlet bound with *Report of the Secretary-Treasurer from April 1, 1882, to December 31, 1883 [...]* and subsequent annual reports], pp. 14-16; Health Sciences Centre Archives/Museum, F4; S4; the numbers are those of the particular by-law.

In fact, the familiar lament about the careless destruction of such records was not long in coming. In his 1883 report, the Secretary-Treasurer, Acton Burrows, compares the Winnipeg General Hospital to the Johns Hopkins Hospital of Baltimore and is forced to declare that his own institution has been deplorably negligent:[36]

> In the valuable collection of essays relating to the construction, organization and management of Hospitals, contributed for the use of the John [*sic*] Hopkins Hospital, Baltimore, Dr. Jones remarks that 'it is true that the statistics of many large Hospitals are not accessible, on account of the neglect to file and preserve the annual records.' It is much to be regretted that these remarks apply to nearly half of the period during which the Winnipeg General Hospital has been in existence. During the past year unceasing efforts have been made to secure the early records of the Hospital, but without avail. The minutes extant only date from May 10, 1878, and the financial accounts from May 1875. The first annual report on file is for the year 1877-8 […].

The message seems to have fallen on deaf ears for there is no further mention of archival preservation that has so far been unearthed either in the annual *Reports and Accounts* or in any of the hospital's papers. Unfortunately, the opposite attitude seems to have prevailed for most of the hospital's history. It seems typical, in fact, that in 1970, presumably in preparation for the change-over from the private Winnipeg General Hospital to the new, public Health Sciences Centre, Winnipeg, the matter of dealing with the existing records was entrusted to the Director of the

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[36] *Winnipeg General Hospital, Report of the Secretary-Treasurer from April 1, 1882, to December 31, 1883,with a list of the Life Governors and Annual Subscribers entitled to vote at the Annual General Meeting, February 11, 1884* ([internally dated] January 30, 1884), p. 7; Health Sciences Centre Archives/Museum, F4; S4. The report for 1877-1878 mentioned by Burrows is neither at the Health Sciences Centre Archives/Museum nor at the Archives of Manitoba.

Housekeeping Department, who reported to the Management Committee on 29 October 1970: "Reported that a new procedure for the destruction of documents was being worked out by his department. He expected that a formal announcement would be made shortly outlining the details for all departments."[37]

Objects, however, always seem to rate more highly than papers. As early as 1888, a "museum" (presumably of pathological specimens primarily) was established in the basement beneath the new operating theatre.[38] It seems likely that this museum, with the addition of numerous specimens prepared by Sydney J.S. Peirce (pathologist at the Winnipeg General Hospital from 1908 to 1918), is the foundation on which the Boyd Museum (now housed in the Faculty of Medicine Archives at the University of Manitoba) was built, which in the expert opinion of Guillermo Quinonez is "one of Boyd's legacies to pathology."[39] A collection of artifacts illustrating the history of nursing at the Winnipeg General Hospital and the Children's Hospital and their respective Schools of Nursing (pins, uniforms, etc.) forms the core of the museum division of the Health Sciences Centre Archives/Museum, which also holds medical instruments and equipment of many different types, some of the latter constructed in-house.

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[37] Winnipeg General Hospital, Minutes of the Management Committee, 29 October 1970, Health Sciences Centre Archives/Museum, F4; S12.

[38] Board of Trustees Minutebooks, 8 October 1888, Winnipeg General Hospital, MG10 B11/Box15, Archives of Manitoba; see also Emma Prescott, "1888 Building Boom: Operating Theatre," *HSC Focus*, vol. 20, no. 3, 22 March 2013, p. 10.

[39] Guillermo E. Quinonez Salmon, "A Study of Medical Specialization: The History of the Department of Pathology of the Winnipeg General Hospital (1883-1957)," (M.A. Thesis, University of Winnipeg, 2007), p. 68.

On the archival side, restricting our attention to textual and photographic records, it was the Winnipeg General Hospital School of Nursing Alumnae Association (which had been in existence since 1904) that turned out to be the first to make a move.[40] In 1933, the Executive Committee of the Association recommended "that an Archivist be appointed to take care of documents etc. belonging to the Alumnae Association." Appointing Stella Pollexfen (graduate of 1917), they asked her to "make arrangements and bring in recommendations to the next meeting of what is required for looking after our records."[41] Although the minutes are silent on the reason for this move, it seems likely that the decision to start the collection process was related to the upcoming fiftieth anniversary of the School of Nursing. A contributor to the 1933 *Nurses Alumnae Journal* known only by her initials (KWE) writes: "It is the story of our school and of our profession as [*sic*] we are building today – between 1933 and 1937 – that is our immediate concern, and the concern of all those who are even remotely associated with it."[42] By October of the following year the Archives had a space, furniture, files and scrap-book, and Stella Pollexfen had been joined by Edith Timlick (class of 1917) and Ruth Monk (class of 1925) as assistants.

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[40] The following short history of archival activities at the Winnipeg General Hospital and the Health Sciences Centre, Winnipeg is based largely on Emma Prescott, "Presentation to Retirees," 2 March 2012, ms.

[41] Winnipeg General Hospital School of Nursing Alumnae Association, Executive Committee Minutes, 5 April 1933, p. 292, Health Sciences Centre Archives/Museum, F1; A2; S3.

[42] *Nurses Alumnae Journal*, 1933, p. 13, Health Sciences Centre Archives/Museum, F1; A2; S2.

Neither the Winnipeg General Hospital itself nor the Health Sciences Centre, Winnipeg as its successor reached a comparable level of organization until 1982, when the latter established the HSC Archives Committee, having previously shipped all the records that could be found to the Provincial Archives of Manitoba. The new committee, led by Elsie McClellan (Assistant to the President) and Pat Edwards (formerly Nursing Staff Coordinator at the Health Sciences Centre and President of the Nurses Alumnae Association), promptly issued a call, by means of a notice appearing twice in the *CentreScope* newsletter, for people "to bring in their stuff."[43] It is not clear how much "stuff" came in at that time, although it filled a storage room behind a custom-built display case of about 20 ft in width in the mezzanine of the Thorlakson Building (built in 1983) until 1997, when the space claims of another department caused the removal of the entire collection. Meanwhile the Alumnae Association's interest in the preservation of their history continued unabated under the leadership of a succession of Alumnae Archivists, including Elaine Tressor (1984–1992), who established the Museum collection in 1987 and in 1985 joined the Association for Manitoba Archivists (the precursor of the Association for Manitoba Archives), which had only recently been created (in 1980); Lyn Stephens (1992–1999), who began looking at better ways to store the archival items; and Anne Crossin (1999–2009), who was instrumental in transforming the Alumni Museum/Archives into the present Health Sciences Centre Archives/Museum.

[43] *CentreScope*, vol. 10, no. 7, September 1982, p. 6; vol. 14, no. 3, March 1986, p. 4.

The loss of the storage space in the Thorlakson Building coincided with the departure of Elsie McClellan from the chair of the HSC Archives Committee. In response, the Health Sciences Centre at last asked the Nursing Alumnae Association in 1998 to serve as "custodians of HSC history" and to "act as archivists for the Winnipeg General Hospital and Health Sciences Centre in a broad sense rather than archiving documents and properties relating strictly to nursing education and nursing practice."[44] In 2003 the Health Sciences Centre established another Archives Committee to "preserve the history and heritage of the HSC and its founding members." Realizing that the volunteer base was no longer self-sustaining since the School of Nursing had been closed in 1993, the Archives Committee in 2006 began to plan for alternative support for a professional archives that would meet four strategic priorities: a professional archivist, dedicated sustainable funding, appropriate space, and a computerized catalogue. With the exception of the last, these conditions exactly parallel those formulated by James A. Low for the archives at the Kingston General Hospital.[45]

In the course of preparing an institutional history, to be published in 2009 as *Healing and Hope*, the Executive Team at the Health Sciences Centre began to realize that a proper archives was called for. A new HSC Archives/Museum

[44] Correspondence from James Rodger, Assistant to the President and Corporate Secretary, Health Sciences Centre to Marylynne Hogg, President, WGH/HSC Nursing Alumnae Association, 11 December 1998, Health Sciences Centre Archives/Museum, Semi-active files.
[45] James A. Low, "Administrative Records Management and Archival Program: The Kingston Experience," *Canadian Bulletin of Medical History* 18 (2001), p. 383.

Management Committee, soon renamed the HSC Heritage Committee, took charge in 2009. As part of the agreement between the Health Sciences Centre and the various "stakeholder groups," the Nursing Alumni established an Endowment Fund, the Health Sciences Centre for their part provided bridge funding, and the first professional Archivist was appointed in 2010. Following accreditation by the Association for Manitoba Archives, the new Health Sciences Centre Archives/Museum joined ICA-AtoM, allowing it to make its catalogue accessible on the Manitoba Archival Information Network.

At an early stage in these proceedings, the HSC Heritage Committee arranged for the acquisition of the materials that had been collected since 1995 by James C. Haworth, Marie-Alice Grassick and other members of the Children's Hospital Archives Group in preparation for the hospital's ninetieth anniversary in 1999. Continuing the earlier efforts of Harry Medovy, they assembled materials that had not been deposited with the Provincial Archives of Manitoba in the 1970s, adding others produced since that date. In 2009 they transferred their records and artifacts to the Nursing Alumnae Archives (now the Health Sciences Centre Archives/Museum), though with the proviso that they would be kept as a distinct collection.

It is no accident, in the light of the history outlined here, that some of the richest holdings of the new Health Sciences Centre Archives/Museum are still in the

area of nursing. It is just as noteworthy, on the other hand, that no special effort appears to have been made, especially by comparison to the book published by Kingston General Hospital for this purpose, to preserve the papers of the various guilds in one place. At least two of them, the Annie A. Bond Guild and the St. Agnes Guild, transferred their records as distinct, "stand-alone" units to the Provincial Archives of Manitoba, while those of the St. John's Guild (with the exception of the annual reports from 1915 to 1939, which are part of the Children's Hospital fonds at the Archives of Manitoba), the Mckinnon Guild, the Chown Guild and the Guild Council are kept at the Health Sciences Centre Archives/Museum. Neither of the archives in question appear to have the records of the Earl Kitchener, Alexandra or Lt. Melville Wood Guilds. Those of the Children's Hospital Bookmarket, which has been a prominent fixture in Winnipeg for decades, are at the Health Sciences Centre Archives/Museum. The records of the Women's Aid Society (later the Women's Hospital Aid Society), the main fundraising arm of the Winnipeg General Hospital, which was formed in 1883 as an integral part of the hospital's work and is mentioned as such in the report of the Secretary-Treasurer for the period from April 1882 to December 1883,[46] are lost, while its successor, the White Cross Guild, have deposited their records from their founding in 1947 onward at the Health Sciences Centre Archives/Museum.

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[46] *Winnipeg General Hospital, Report of the Secretary-Treasurer from April 1, 1882, to December 31, 1883, with a list of the Life Governors and Annual Subscribers entitled to vote at the Annual General Meeting, February 11, 1884* ([internally dated] January 30, 1884), p. 3; Health Sciences Centre Archives/Museum, F4; S4.

The relatively recent date of the Health Sciences Centre Archives/Museum, on the one hand, and the more or less untouched status of the Winnipeg General Hospital Collection at the Archives of Manitoba, on the other, are not the only reasons why it seems premature to attempt more than a preliminary assessment of the archival legacy of the Winnipeg General Hospital and its successor. A complex organization housed on a large site made up of multiple buildings, the nooks and crannies of the Health Sciences Centre continue to yield up the occasional find. As recently as January 2014, for instance, a locked cupboard was found to hold a treasure trove of School of Nursing records amounting to 50 ft, mainly the minutes of meetings and course outlines dating back to the early 1940s; another batch of records measuring 6 ft and covering the period from the early 1940s until 1973 was presented to the archives by Facilities Management during the summer of 2014. In short, the saga continues.

Records Held Here and There (or, Record Groups Split between the Health Sciences Centre Archives/Museum and the Archives of Manitoba)

It is clear that even in its present, largely unprocessed state, the Winnipeg General Hospital Collection at the Archives of Manitoba constitutes by far the major portion of the archival record for the century of the Winnipeg General's existence. It seems remarkable, on the other hand, that some of the individual record groups held

there show significant gaps and that in some of the most important sets of records the missing volumes are, in fact, found at the Health Sciences Centre Archives/Museum. But without a detailed study of the archival descriptions and perhaps even the papers themselves there is no telling whether the distribution of the records over the two archives involved is systematic and deliberate or simply an accident of where they were kept in the complex of buildings that was the Winnipeg General Hospital (and now is the Health Sciences Centre) or on what day they were dispatched or at which point the truck happened to be full.

The most striking gap is that found in the "Minutes of Meetings of the Board of Trustees:" the Archives of Manitoba has an initial run from 1878 to 1945 and, again, a final run from 1971 to 1973 but for the quarter-century in between, from 1945 to 1970, the records in this series are kept in the Health Sciences Centre Archives/Museum (reference code F4; S1).

The situation with respect to the parallel set of "Minutes of the Executive Committee of the Board of Trustees" is even more obscure: the Health Sciences Centre Archives/Museum holds the partial run from 1957 to 1969 (reference code F4; S2) but there seems to be no entry in the finding aid at the Archives of Manitoba for these important records. (The significance of a mid-1950s date for a change in the preservation of records will be explored below.)

For the "House Committee," too, which dealt with "a great variety of things which affected the hospital at the time,"[47] the minutes for the early twentieth century are located at the Archives of Manitoba while those for the period from 1939 to 1951 are held by the Health Sciences Centre Archives/Museum (reference code F4; S7). No trace has so far been found of the corresponding records for the final two decades of the Winnipeg General's existence (even though the committee figures in the annual *Reports and Accounts* for 1953).

In the case of the "Finance Committee," the breaks in the run of minutes are more complex. The Health Sciences Centre Archives/Museum holds two runs, an early one from 1913 to 1919 and a late one from 1949 to 1957 (reference code F4; S5). The earlier one is likely to be of special interest to historians since the time frame includes the First World War and the influenza epidemic of 1918-1919; it may even include at least part of the Winnipeg General Strike of 1919. The Archives of Manitoba has four runs: 1900-1912, 1919-1934, 1934-1948, 1951-1952. The finding aid makes no mention of the reason why the two middle runs are treated separately, and the question of the apparent overlap between the 1951-1952 run at the Archives of Manitoba and the 1949-1957 run at the Health Sciences Centre Archives/Museum also remains to be explored.

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[47] HSCA/M catalogue; see the institutional entry for the Health Sciences Centre Archives/Museum on the Manitoba Archival Information Network: http://nanna.lib.umanitoba.ca/atom/index.php/health-sciences-centre-archives.

Only a small part seems to have survived of the minutes of the "Building Committee" but that seems to correspond roughly to the big building boom that preceded World War I. The Archives of Manitoba has the years 1906 to 1909, while the records for 1910 to 1913 are kept at the Health Sciences Centre Archives/Museum (reference code F4; S6).

The annual *Reports and Accounts*, finally, which cover the years from 1884 to 1972, represent the extreme case of the same records held in more than one repository. As printed volumes, they are in fact present in both archives (at the Health Sciences Centre Archives/Museum under the reference code F4; S4), although the Archives of Manitoba does not list the volumes for 1888 and 1928. The same is true, with a minor discrepancy, of the hospital newsletter, called *The Generator*, a much less formal publication and therefore subject to the familiar problems of missing issues that are found with all ephemeral print products. The Archives of Manitoba, as it turns out, has a run starting in 1960 while the run held by the Health Sciences Centre Archives/Museum (reference code F4; S3) actually begins in 1957.

Photographs constitute a distinct type of record but they, too, are housed at both the Archives of Manitoba and the Health Sciences Centre Archives/Museum. The Winnipeg General Hospital series [graphic material] at the Archives of Manitoba

contains 439 black-and-white photographs dating from 1888 to 1971, which were accessioned in 1977. The Health Sciences Centre Archives/Museum acquired the entire collection of Public Relations negatives of BioMedical Communications, amounting to over 23 m of shelf space, when that department closed in 2009. In addition, the Health Sciences Centre Archives/Museum holds other photographs, not yet counted or fully catalogued, related to the School of Nursing, their Alumnae/Alumni Association, and the Winnipeg General Hospital itself. The photographs in this last class may or may not be originals and may or may not be copies of those held at the Archives of Manitoba. To add to the confusion, some photographs (in particular most of those taken before 1953, when the Department of BioMedical Communications was launched) may also be at the Faculty of Medicine Archives as the Faculty had the initial photography department which served both the Medical College and the Winnipeg General Hospital. Finally, some images may also exist as part of the sweep carried out in the 1970s by the Western Canada Pictorial Index.

Records Held at the Health Sciences Centre Archives/Museum

As the history of the Health Sciences Centre Archives/Museum suggests, the most prominent part of the collection are the records of the School of Nursing Alumnae Associations of the Winnipeg General Hospital and the Health Sciences Centre, Winnipeg and their Schools of Nursing (F1).

As a result of the amalgamation that led to the formation of the Health Sciences Centre in 1973, the holdings of the Health Sciences Centre Archives/Museum include three separate fonds for the three founding institutions: the Winnipeg General Hospital fonds (F4), the Children's Hospital of Winnipeg (1909–1973) fonds (F2), and the Manitoba Rehabilitation Hospital fonds (F7), though the records of the last-mentioned are mainly kept as part of the Sanatorium Board of Manitoba fonds at the Archives of Manitoba.[48]

Among the Winnipeg General Hospital records kept at the Health Sciences Centre Archives/Museum exclusively, the most diverse (and, perhaps, interesting) may well be the "Minutes of the Management Committee" from 1970 to 1973, dealing with administrative affairs and notably including a new procedure for the destruction of documents (reference code F4; S12).

The group dating back the furthest is the "Miscellaneous Materials" (archived under F4; S8). The earliest part of this group, dating from 1901 to 1907, consists of a "Register of Lands belonging to the Winnipeg General Hospital" along with contracts and tenders. A second set that may evoke special interest as it covers the war years 1914–1918 includes, among other material, rules for operations and the daily

[48] Note that another part of the Sanatorium Board of Manitoba records is still held by the Manitoba Lung Association.

treatment of patients. The Paraffin Block Record Book 1924–1925 may be of interest with respect to the work pioneered by the pathologist Sydney J.S. Peirce.

Another group are the "Publicity Materials" (reference code F4; S11) which begin with a pamphlet addressed to the citizens of Winnipeg by the Board of Trustees in 1910 and provide a remarkable sample of the published ephemera and brochures illustrating the hospital's anniversaries and celebrations, notably a historical booklet, *Safeguarding Motherhood: The Winnipeg General Hospital Maternity Wards 1880–1950*, published for the official opening of the new Maternity Pavilion in 1950.

The remaining series of records are probably best dealt with here under the heading of miscellaneous materials. They range from a typed copy of a "General History of the Winnipeg General Hospital" for the period from 1946 to 1957 (reference code F4; S14) to newspaper clippings (reference code F4; S23), and certificates (reference code F4; S21).

Like many similar institutions in its day, the Winnipeg General Hospital provided on-the-job training for people straight out of high school. In addition to the School of Nursing, technical staff trained in-house included operating room technicians, laboratory technicians and medical records librarians. The records for

the training of the various technicians are missing, while those for the School of Medical Records Librarians have survived (reference code F4; S17).

Records Held at the Archives of Manitoba

In outlining the contents of the Winnipeg General Hospital Collection at the Archives of Manitoba, we follow the finding aid prepared by J.M. Sinclair (Archives of Manitoba); an examination of the material itself would go far beyond the scope of the present study. It is important to stress at the outset that the collection in its present state seems to reflect the more or less random transfer from the late Winnipeg General Hospital of the contents of certain administrative offices and that the resulting "Collection" vividly recalls the situation so dramatically described (earlier in this chapter) for the Baker Memorial Sanatorium of Calgary by Janice Dickin McGinnis.

While the contents of the Winnipeg General Hospital Collection itself are given without accession numbers in the finding aid, they are preceded in the list by two other sets of records which deserve at least a brief mention here. The first is the HSC fonds, with the conjoined accession numbers 1991-17 and 1996-39. It appears to have come from a legal office, consisting largely of agreements with the Province of Manitoba and other healthcare institutions, of real estate agreements and construction contracts, and union contracts and the like with CUPE, the Manitoba

Paramedical Associations, the Manitoba Organization of Nursing Associations, and the International Union of Operating Engineers from 1973 onward; in short, strictly Health Sciences Centre records. But the HSC fonds also includes a remarkably disparate assortment of papers (starting with P6806/3) that appear to have come from a similar office at the Children's Hospital: dealing with the bequest of Charles H. Enderton (creator of the Crescentwood neighbourhood) in 1920, a "tax statement" of 1934, a nameless and undated "court case" along with a "License to use denatured alcohol" and a "License for importing still" of 1925 and 1926, respectively (that is, squarely within the prohibition period), and then, rather out of context, a set of "Manitoba Medical Centre Minutes 1959-61."

Under the accession number 1988-334 there are four volumes of submissions to the Hunt Commission, 1970 (which dealt with admitting privileges), and under accession number 1991-11 a "Minute Book of Medical Centre Apartments," 1953-1974 that deals with staff quarters built in 1953 and 1955 just west of the Women's Pavilion on Notre Dame Avenue.

A much more coherent and promising picture is presented by the Children's Hospital fonds proper (accession number 1980-121), which includes long (though rarely unbroken) runs of Board and Committee minutes, notably the Inaugural Meeting of the Board in 1908), annual reports (1909-1948), early fiscal records,

"Guest Registers" from 1932 to 1953 and again from 1957 to 1971, and a 25-year run (1915-1939) of the annual reports of the St. John's Guild.

The Winnipeg General Hospital Collection proper, finally, which seems to bear no accession number, preserves a mass of documents and series. Supplementing the "Minutebooks of the Board of Trustees" and the various administrative committees already reviewed as part of the holdings split between the Archives of Manitoba and the Health Sciences Centre Archives/Museum, the most important set of records may well be the "Indices to Committee Board Meetings" (in volumes that seem convoluted and in need of careful analysis), which run from 1898 to 1954. Other series with an end date in the mid-1950s are the "Records of Attendance at Committee Board Meetings" from 1913 to 1956, the "List of Board Committee Members" from 1934 to 1951, and "Hon. Attending Staff – Minutes of Annual and Executive Meetings" from 1919 to 1954.

The remarkable agreement in the end dates of these series coincides with a sudden and dramatic increase in the number of committees and departments submitting reports to the *Reports and Accounts* for 1955. This is the time, also, of the dramatic post-war growth in births and immigration and the corresponding building boom in and around the Winnipeg General Hospital (Maternity Pavilion, 1950; School of Nursing, 1956; Interns' Residence, 1957; Children's Hospital, 1957; North

Wing, 1958; Extension to Psychopathic Hospital, 1959; Lennox Bell House, 1960). Finally, this is the very time when an assured level of public funding is achieved with the implementation of the Manitoba Health Services Act of 1958. In their practical impact on the institution, these momentous trends and events suggest either, at the most mundane, a massive movement of rooms and their contents or, at the structural level, a major reorganization (perhaps occasioned by the retirement after 29 years of Harry Coppinger and the arrival of Peter Swerhone, who served in a leading administrative role from 1958 to 1985). They may further have been brought about by the growing role of public funding and the new accountability requirements it carried with it – or might it merely be a change in the office of the corporate secretary (a mystery that might be solved by reference to the "Index to Filing Cabinets, Office of Administration, belonging to the Private Secretary,"[49] which also shows an end date of 1957).

For the earlier part of the twentieth century, the finding aid includes "Medical Staff Minutes" from 1908 to 1917. The only clinical unit for which minutes of its staff meetings appear in the finding aid is the Department of Obstetrics and Gynecology, which left behind a set ranging from 1941 to 1964.

[49] "Index to Filing Cabinets, Office of Administration, belonging to the Private Secretary," Winnipeg General Hospital fonds, MG10 B11/Box 11/9, Archives of Manitoba.

The very earliest period of the hospital's operation is represented, in addition to the printed annual reports which have already been discussed, by a "Visitors' Book" from 1876 to 1922 and a ledger and cash book from 1884 and 1885, respectively, to 1892 and 1890. There is also a subset of records under the general heading of "Medical Staff and Historical Records – Alphabetical List of Life Governors Historical Volume," which begins with the "Members of the Board of Directors" from 1878 to 1913 and further lists representatives of City Council, Officers, and "Attending Physicians" from 1883 to 1911, "Resident Medical Assistants" from 1891 to 1911, and several types of statistical information for the years from 1877 to 1906, 1908, and 1910, respectively. Also a set of "Resident Medical Officer notes" from 1880 to 1902 (although it is not clear from the list whether the notes are by or about these Medical Officers), a "Record of Services with remarks by Attending Physicians 1914-15," and a "List of Interns according to years" from 1882 to 1957 (and, again, from 1946 to 1958). Finally, an "Alphabetical List of Medical Staff" from 1871 to 1935 and an "Alphabetical Card Index of Medical Appointments [...] and Record at Winnipeg General Hospital" compiled "about 1957;" once again the end dates seem noteworthy.

Almost in the manner of a footnote, finally, the Winnipeg General Hospital Collection at the Archives of Manitoba includes a typed manuscript of 159 pages that was to have been published by Hyperion Press about 1981: "A Hundred Years of

Health: A Brief Survey of the Winnipeg General Hospital" by Beatrice Fines. The negatives of the illustrations that were to have appeared in this book are preserved at the Health Sciences Centre Archives/Museum.

Papers Preserved in Far-Flung Places

Having reviewed the holdings of the two archives directly concerned with the Winnipeg General Hospital and its successor institution, we also need to consider the possibility that the personal papers of major figures in their history may not be held in either of them.

One of the earliest historiographical sources for the history of the Winnipeg General Hospital is the "Historical Sketch of the Charitable Institutions of Winnipeg" of Mrs. George Bryce, published in 1899, which reports – presumably on the authority of the Rev. Dr. George Bryce, the author's husband, who had been present – that "the Winnipeg General Hospital was organized on 13 December 1872" and then provides a list of the men (for they all were men) who made up "the board of management applying for the Act [of Incorporation]."[50] While historians might be more interested in the composition of that group of fifteen, which included two

[50] Mrs. George Bryce [i.e., Marion Bryce], "Historical Sketch of the Charitable Institutions of Winnipeg," *Transactions of the Manitoba Historical and Scientific Society*, *54*, especially pp. 1-11, 1899; the same list also appears (with minor variations in the abbreviation of given names) in the Winnipeg General Hospital, *Act of Incorporation (with Amendments), Consolidated Statutes, Chap. XXVI (compiled by order of the Board of Directors by Acton Burrows, Secretary, 1882),* Health Sciences Centre Archives/Museum, F4; S4.

"medical men" and three men of the cloth (one identified by his title, the other a well-known Methodist, George Young, and the third identified as the author's husband in a prefatory note), from an archivist's perspective the most obvious and interesting question is whether or not they have left any personal papers, if such papers have survived, and where they might be kept.

Of the nine businessmen and politicians on the list, including even a francophone in the person of Joseph Royal and most of them well known as boosters of the emerging city of Winnipeg, no fewer than eight rate an entry in the *Dictionary of Canadian Biography*. But for only two of them does the *Dictionary of Canadian Biography* mention their role as founders (in the widest sense) of the Winnipeg General Hospital: A.G.B. Bannatyne and W.G. Fonseca. With respect to their papers, the Archives of Manitoba has holdings for both,[51] and further also for Andrew McDermot,[52] who presumably played no overt part in these proceedings due to his advanced age; he was born in 1790. Bannatyne not only chaired the initial meeting that resulted in the establishment of the Winnipeg General Hospital and for ten years headed its Board; he also provided it with its initial quarters.[53] In fact, Bannatyne and McDermot, his father-in-law, also were the major benefactors of the fledgling

[51] J.E. Rea, "Andrew Graham Ballenden Bannatyne," *Dictionary of Canadian Biography,* vol. 11, pp. 44-47, 1982; Randy R. Rostecki, "William Gomez Fonseca," *Dictionary of Canadian Biography,* vol. 13, http://www.biographi.ca/en/bio/fonseca_william_gomez_13E.html (accessed summer 2014).
[52] Barry E. Hyman, "Andrew McDermot," *Dictionary of Canadian Biography,* vol. 11, pp. 545-546, 1982.
[53] Rea, "Andrew Graham Ballenden Bannatyne," p. 47.

institution, together donating the site on which it still stands today between Bannatyne and McDermot Avenues.

Without a detailed search of the holdings of the Archives of Manitoba one cannot tell whether or not any of the papers preserved there, for example those in MG2, C14, which appear among the archival references in both biographies, deal with the earliest phase of the Winnipeg General Hospital's history. In the case of Bannatyne one would also have to examine the Archives de l'Archevêché de Saint-Boniface. For another prominent name of the Bryce list, that of J.H. Ashdown, one would have to consult the holdings of the City of Winnipeg Archives. In short, the personal papers of the founding group are housed in a variety of archives, and the collections in which they are held are entirely distinct, in the case of the Archives of Manitoba, from the main body of the records of the Winnipeg General Hospital. If one were looking for a particular set, in short, the search could not be limited to the archives located in Winnipeg.

The same general pattern presumably holds for the papers of the other major figures of the early phase, the physicians, "lady superintendents," deans of the medical faculty, etc., except that their collections may be held in more specialized repositories, for instance the archives of the College of Physicians and Surgeons of

Manitoba, the Faculty of Medicine, the College of Registered Nurses of Manitoba, or even Library and Archives Canada.

There is no telling where a particular set of personal papers may have ended up. Two examples from the Winnipeg General Hospital School of Nursing will serve as illustration. Ethel Johns is a major figure, in Winnipeg as on the larger canvas of nursing and labour history: alumna, labour activist and author, Superintendent of Nursing at Children's Hospital and, after the General Strike of 1919, founding Director of the first university nursing program in Canada at the University of British Columbia; her papers are kept at the archives of the University of British Columbia.[54] Those of Isabel M. Stewart, a founder of the Winnipeg General Hospital Nursing Alumnae, an early champion of the formal registration of nurses, and later Professor of Nursing at Columbia, are held in the Nursing Archives of the Teachers College Library at Columbia University in New York.[55]

Papers Not Found and Papers Lost

For some individuals, of course, we simply do not know if they left any personal papers behind. This seems to be the case for Sydney J.S. Peirce, the eminent

[54] http://www.library.ubc.ca/archives/u_arch/johns.pdf; see also Margaret M. Street, *Watch-fires on the Mountains: The Life and Writings of Ethel Johns* (Toronto: University of Toronto Press, 1973) and, more recently, Sonya J. Grypma, "Profile of a Leader: Unearthing Ethel Johns's 'Buried' Commitment to Racial Equality, 1925," *Nursing Leadership*, vol. 16, no. 4, December 2003, pp. 39-47, which deals with her report on the status of black women in nursing in the United States.

[55] See http://nanna.lib.umanitoba.ca/atom/index.php/health-sciences-centre-archives%3bisdiah, http://umanitoba.ca/faculties/nursing/info/stewart.html.

bacteriologist and pathologist who had developed the Winnipeg General Hospital vaccine for typhoid fever. As Guillermo Quinonez points out in this history of the hospital's Department of Pathology, there is an "absence of pertinent archival documentation" concerning Pierce's own appointment; the lecture on the controversial circumstances of the appointment of his successor, Boyd, "and its consequences" which J. Hoogstraten gave in 1987 was based on sources he described as "fragmentary, incomplete and varied" since "a large portion of the College's archives were lost in the 1950 flood."[56]

For others, we only know that their papers did exist at one time, and for yet others, finally, we even know when and where their collection of personal papers ceased to exist. The papers of Annie Bond, founder of the Children's Hospital in 1909 and until her death in 1943 its untiring supporter, are the subject of a sad tale told by the Winnipeg antiquarian Andrew Taylor.[57] After Bond's death, her papers (along with those of her husband John H.R. Bond, who had established the first x-ray facility in Winnipeg) were packed up in boxes and "deposited in one of the basement storage rooms" at the Children's Hospital, then located on the left bank of the Red River just south of the Redwood Bridge and severely affected by the 1950 flood. There is no evidence to show whether or not the anonymous compiler of the undated

[56] Guillermo E. Quinonez Salmon, "A Study of Medical Specialization: The History of the Department of Pathology of the Winnipeg General Hospital (1883-1957)," (M.A. Thesis, University of Winnipeg, 2007), pp. 46, 59n; the quote from Hoogstraaten is part of this note.
[57] Andrew Taylor, "The Bond Papers," *Manitoba History*, no. 22 (Autumn 1991).

pamphlet, *The Children's Hospital: A Story of its Inception and Growth*,[58] had access to the Bond papers. But this is where, as Taylor assures us, Harry Medovy went through them, presumably at an early stage of preparing his history of the Children's Hospital,[59] though we cannot tell whether this event took place before or after the 1950 flood. At any rate, when the hospital moved to its new home next to the Winnipeg General Hospital on William Avenue in 1959, storage space turned out to be scarce, and the papers of Annie Bond simply vanished.

Having examined the archival situation at three representative institutions in some detail, we are now ready to turn to the larger picture and survey the national scene by means of a more formal, systematic survey.

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[58] [anon.], *The Children's Hospital: A Story of its Inception and Growth* (Compiled and Printed by Bulman Bros. Limited, Winnipeg, undated), pp. [1]-23; this booklet appears to have been issued in the late 1940s or early 1950s to be used in fundraising for the new Children's Hospital, completed in 1957; Health Sciences Centre Archives/Museum.

[59] Harry Medovy, *A Vision Fulfilled: The Story of the Children's Hospital of Winnipeg, 1909-1973* (Winnipeg: Peguis Publishers, 1979).

CHAPTER FOUR

SURVEYING THE FIELD

The review of the historical background and the archival literature conducted in Chapters 1 and 2 suggests that, in recent years, the state of administrative archives in Canadian healthcare facilities has not been adequately documented. In order to help remedy this problem, I carried out a new assessment of the administrative archives of a representative sample of Canadian hospitals.

My interest in the institutional records of hospitals arises from my experience as the Archivist of two such institutions in two provinces, Ontario and Manitoba.[1] These archives turned out to be primarily corporate-style archives, but only in one of them was the presence of an archives matched by the expected records management program.

[1] I was Archives Co-ordinator at Bloorview MacMillan Children's Centre, Toronto for three years (2003-2006) and have for the past four years been Archivist at Health Sciences Centre, Winnipeg.

In many cases the archives will have come into existence in isolation and more or less by accident (rather than as the result of a planning process) – for example, on the initiative of an active retiree rather than as a solid part of the corporate structure of the institution. In view of these facts, which seem typical of the origins of these types of archives, my survey paid special attention to the relationship between the administrative archives and their parent body.

In structural terms, the most salient question concerns the types of archives and their place within the organizational structure of the institutions; in addition, the 2013 survey also explicitly deals with historical questions such as the number of years the archives had been in existence; if it had been closed (and perhaps re-opened); and whether it had been shifted around within the organizational structure of the institution. The 2013 survey further had to respond to a number of important issues that have only arisen since the previous survey conducted by the Association for Canadian Archivists in 1979. These issues included, but are not limited to, the advent of e-records and the complete collapse of the funding mechanism on which such archives had traditionally relied (for example the Hannah Institute for the History of Medicine in Ontario).

As the historiographical review in Chapter 1 indicates, institutional histories of Canadian hospitals occasionally yield valuable information about the holders and locations of various types of record; unfortunately, however, this information will

only in the rarest cases address the crucial issue of the relationships between the archives and the records management program that feeds it.

The 2013 Survey and the ACA Survey of 1979

Given the extraordinary diversity of hospital archives, the best approach clearly is a formal, descriptive survey. In order to make such a survey manageable within the confines of an M.A. thesis project, I limited it to a set of 60 Acute Care (General) Healthcare Facilities of 300 or more beds and with a teaching component.

Any new survey of administrative archives in Canadian healthcare institutions will take as its point of reference the comprehensive survey which the Association of Canadian Archivists (ACA) conducted in 1979;[2] the full documentation of this survey is preserved at Library and Archives Canada in the Association of Canadian Archivists' fonds.[3]

Both surveys drew on the same published source, the *Guide to Canadian Healthcare Facilities* (earlier called the *Canadian Hospital Directory*) of the Canadian Healthcare Association, to identify the institutions to be surveyed and to retrieve the required contact information for those to whom the survey questionnaire

[2] For a fuller discussion of the ACA survey see Chapter 2.
[3] Association of Canadian Archivists' fonds, MG28-I340, Mikan no. 97684, Library and Archives Canada; for this reference I am indebted to Duncan Grant at the ACA and Robert Fisher at Library and Archives Canada.

would most appropriately be addressed or who would be most likely to respond. But this is where the similarities end.

It would not have been feasible simply to replicate the ACA survey within the severely limited confines of an M.A. thesis project, or even to repeat it in part. It had been the goal of the ACA survey of 1979 to assess the field of Canadian healthcare archives in its entirety while time constraints and other practical considerations forced me to limit the 2013 survey to a representative sample. In 1979, the complete set of healthcare institutions in Canada numbered 740; the 2013 survey, by contrast, was limited to a set of 60 Acute Care (General) Healthcare Facilities of 300 or more beds and with a teaching component.

The questionnaires, too, could hardly have been more different: the ACA instrument ran to three tightly typed pages containing 156 questions while the 2013 questionnaire was carefully designed to fit on the two sides of a single sheet of paper in the hope that its format and modest size would encourage a good response. In the event, it was one of the major complaints from respondents that there was not enough room to fit in additional information; this indicates that the respondents were keen to elaborate on the issues being explored.

More important, the ACA survey was highly structured and quantitative in design whereas the 2013 questionnaire was deliberately open-ended and qualitative.

In the end, the return rate of the ACA survey was 29% while the 2013 had an overall return rate of over 50% (with the details to be discussed below). Though this new assessment does not, of course, claim to approximate the ACA survey in depth and breadth,[4] it should provide a useful preliminary baseline for comparative and historical evaluation.

The overall scope of the survey, the definition of the sample and the structure of the questionnaire along with all the practical implications of these fundamental issues add up to the most important reason why I did not simply replicate the ACA survey. There are, however, also some substantive differences that follow from the many developments that have taken place during the intervening three and a half decades. The last quarter of the twentieth century and the first decade and a half of the twenty-first were a time of extremely rapid and seemingly ever-accelerating change. On the technological side one need only mention the entrenchment of electronic record-keeping and the emerging world of multi-access integration and cloud storage. In the social and economic domain, the large-scale reorganization of Canadian healthcare institutions exacerbates the effects of these technological changes, and their pervasive use in everyday life has raised the expectations of all archives users, and healthcare archives are no exception. Finally, the prominence of privacy legislation that has increased dramatically since 1979 and the call for public

[4] Barbara L. Craig, "The Canadian Hospital in History and Archives," *Archivaria* 21 (Winter, 1985-1986), pp. 52-67.

accountability that accompanies the fiscal stresses of universal healthcare constitute two massive cultural changes that exhibit all the signs of creative tension between them. While not all of these issues are entirely new in 2013, the four factors of electronic records, institutional reorganization, public accountability and privacy legislation taken together define a radically new world.

Limitations of the 2013 Survey

The goals of the 2013 survey were much more modest than those of the ACA survey of 1979. At the same time, the design, implementation and analysis of this survey proved to be a learning experience. It highlighted the fact that completing surveys as a respondent is not the same as creating them, and that the researcher needs to be aware of the complexities of creating a survey, from isolating the issues and defining the strategy and the sample to devising the tactics of eliciting the responses and drafting and structuring the instrument, and finally of analyzing the responses.

Unfortunately the instrument used in the 2013 survey turned out to be not nearly as highly structured as it should have been in order to permit structured analysis of the responses. An example of this is the location in the sequence of Questions (1), “Does your Health Care Facility have an administrative / corporate / business archives that is distinct from patient records?”, and (5), “Where is your archives located in the overall organizational structure of your institution?” Both

questions were related to organizational structure but were placed near questions about dates of establishment and publication data.

There were also major problems with the arrangement and choice of phrasing for Question (7) and Question (10), which resulted in a high proportion of skewed answers for both of them.

Question (7) asked "How many staff positions (FTE) does your archives have?" in combination with (7a) "How many of them are volunteers?" The confusion between the number of FTE's and the number of volunteers that is suggested by the responses is due entirely to the way the two questions were presented as a main question with a subsidiary question. Turning to the two subsidiary questions, (7a) and (7b), it should have been clear that their juxtaposition would be confusing to respondents since they deal with widely disparate topics: (7a) "How many of them are volunteers?" versus (7b) "What are their training and certification levels in archival studies?". These are the types of flaws in the questionnaire which a test run would presumably have flagged.

A classic example of the importance of sequencing is offered by Question (10), where Question (10b) is in the form of a content question, "**How do you** handle electronic records?", which is both preceded and followed by yes/no questions: (10a) "**Do you** have museum artefacts?", (10c) "**Do you** accept born digital and/or digitized

records?". As a result of its placement between (10a) and (10c), Question (10b), too, was widely read, on the evidence of the responses, as if it had been a yes/no question as well, i.e., "**Do you** handle electronic records?" This problem, too, would probably have been highlighted if a test run had been conducted.

With 31 of the 60 questionnaires that were sent out being returned, the response rate appears high. It should be kept in mind, however, that this impressive number of questionnaires returned is a gross value, which soon dwindles as other factors are considered. Once the returns are examined in detail, only two thirds of the 31 institutions that responded actually participated in the survey. The remaining third were kind enough to respond but indicated that they did not want to participate.

Moreover, not all of the 20 participants answered every question, and some of the answers turned out to be opaque. The best results were for the first four questions, with between 19 and 20 responses. The number of responses to the other questions ranged from 16 to 18, with two questions, (9) and the first part Question (10), at the lowest with 9 responses each.

In sum, readers who might wish to use the results of the 2013 survey will have to keep in mind that the limitations outlined above are indicative of a survey process that may not in all respects match the high standards one would expect of more formal, large-scale surveys. Given the questions about reliability and robustness

raised above and in the discussion of the individual questions, the data thus are to be used with caution.

Despite all the problems presented by the 2013 survey and in view of the structural diversity of the institutions in which a respondent had to be tracked down, it still seems remarkable that the response rate actually exceeded 50%. While this proportion includes a number of empty responses, the great majority of the replies received were carefully prepared and often thoughtful. The results are correspondingly valuable. In addition, it is worth noting that several respondents offered to discuss the issues raised by the survey in further detail.

Defining the Domain

The survey was based on a representative sample of healthcare facilities. Based on my professional experience, the subset of institutions most likely to have an archives consists of acute care teaching hospitals of substantial size. In fact, a careful study of the *Guide to Canadian Healthcare Facilities* showed that there is, of course, a correlation between the properties of being an acute care hospital and a teaching hospital, and it is not surprising that these two factors are also correlated with size. Another argument in favour of defining the sample in this fashion is the hope that teaching hospitals may show the beneficial influence of a university or faculty archives and/or library.

The *Guide to Canadian Healthcare Facilities* (2012, as compared at the last moment to the newly published version of 2013) yielded a list of 60 Acute Care (General) Healthcare Facilities of 300 or more beds and with a teaching component. In establishing the sample, the terms 'Acute Care', 'General Hospital', and 'Teaching Component' are here used as given in the *Guide to Canadian Healthcare Facilities* (2013). Given the disparities that exist from one institution to the next, and from one jurisdiction to another, it would go far beyond the scope of the present study to enter into a discussion of the technical/legal definitions of these terms. In short, while the above terms are here taken in their ordinary sense (e.g., not pediatric, rehabilitative, or long-term), the criterion of size turns out to be more convoluted.

What follows are three tables; two show the distribution of Canadian Acute Healthcare Facilities with a Teaching Component by bed count and province for 2007 and 2011. The third shows a comparison, by bed count and province, of a single year, indicating the vast difference between numbers of hospitals at the 300 versus 400 bed count in 2013. These tables were created to show how the survey sample was chosen for this project.

The minimum size criterion of 300 beds was the result of a pilot study which at that time did not include Quebec as it was felt that, given the differences in the legal system and even the priorities given to archival records by that province, the results would differ significantly. The pilot study was undertaken during the spring

of 2011, at which time the most current data to hand was the 2007 edition of the *Guide*. The results of this study, summarized in Table 1, indicated that there was a significant, natural break between hospitals in the range of 300 or more beds and the next smaller class (which in Manitoba, for example, does not exceed 100 beds).

Table 1: Distribution of Canadian Acute Care Healthcare Facilities with a Teaching Component (according to the 2007 Guide) by Size (Bed Count) and Province (without Quebec)

PROVINCE	NUMBER OF BEDS PER FACILITY				
	0-99	*100-199*	*200-299*	*300-399*	*400+*
British Columbia	5	3	3	1	2
Alberta	13	1	1	2	6
Saskatchewan	2	1	3	3	–
Manitoba	5	–	–	1	2
Ontario	12	13	8	13	13
New Brunswick	2	–	–	3	1
Nova Scotia	1	1	1	–	1
Prince Edward Island	–	–	–-	–	–
Newfoundland and Labrador	9	3	1	1	–
North West Territories	–	–	–	–	–
Yukon Territory	–	–	–	–	–
Nunavut Territory	–	–	–	–	–
Canada	49	22	17	24	25

By 2011, as shown in Table 2, this break had shifted upwards by 100 beds, due presumably to a wave of amalgamations and similar changes in institutional structure. In addition, it was suggested that, for all the differences that could be

expected in Quebec, a review of Canadian hospital archives should not omit Quebec, and so it was included in the review of the 2011 *Guide*.

Table 2: Distribution of Canadian Acute Care Healthcare Facilities with a Teaching Component (according to the 2011 *Guide*) by Size (Bed Count) and Province (including Quebec)

PROVINCE	NUMBER OF BEDS PER FACILITY					
	0-99	*100-199*	*200-299*	*300-399*	*400-499*	*500+*
British Columbia	4	4	2	1	–	2
Alberta	13	1	1	3	1	4
Saskatchewan	3	1	3	2	1	–
Manitoba	6	–	–	1	1	1
Ontario	11	14	8	12	5	9
Quebec	11	11	8	3	9	10
New Brunswick	2	–	–	3	–	1
Nova Scotia	1	1	1	1	–	1
Prince Edward Island	–	–	–	–	–	–
Newfoundland and Labrador	10	4	–	1	–	–
North West Territories	3	–	–	–	–	–
Yukon Territory	1	–	–	–	–	–
Nunavut Territory	–	–	–	–	–	–
Canada	65	36	23	27	17	28

Caught on the horns of the dilemma between the size and the number of institutions, I have chosen to retain the original criterion as under the updated criterion of 400 beds per institution the number of institutions in some of the less populous provinces would approach zero. Note that even the original minimum of 300 beds caused the disappearance from my study of one province and all the territories. With an updated bed count of at least 400, a substantial proportion of institutions would have been excluded even in such large provinces as Alberta and Ontario.

Table 3: Comparison of Institution Size (Bed Count) and Frequency by Province (according to the 2013 *Guide*)

PROVINCE	300+ BEDS (2013)	400+ BEDS (2013)
British Columbia	4	2
Alberta	7	5
Saskatchewan	2	1
Manitoba	3	2
Ontario	18	10
Quebec	19	11
New Brunswick	4	1
Nova Scotia	2	1

Prince Edward Island	–	–
Newfoundland and Labrador	1	–
North West Territories	–	–
Yukon Territory	–	–
Nunavut Territory	–	–
Canada	60	33

The criteria discussed above, including the size minimum of 300 beds, yielded a sample of 60 institutions to be surveyed.

Choosing the Individual Respondents

Recognizing that to send a survey questionnaire "cold" into large and amorphous institutions would risk yielding poor results, or no results at all, it seemed prudent to use a two-contact method (to be detailed below) and therefore make a special effort to identify those individuals on the staff of the 60 institutions who would be most likely to respond.

The initial step in this process relied on a variety of publicly available and semi-public sources, including the *Canadian Council of Archives Directory*,[5] the *ACA Members Directory* including the Health Archivists Special Interest Section

[5] Canadian Council of Archives: www.cdncouncilarchives.ca (last accessed 19 March 2013).

(HASIS),[6] and the *Coalition of Canadian Healthcare Museums and Archives*[7] as well as the directories produced by each of the provincial archives associations.[8] By consulting all of these directories I hoped to ensure that institutions which may for a variety of reasons (including notably the cost of membership) not be a member of one or the other of the various associations would not be omitted. I further examined the Archives Canada website (the Canadian Archives Information Network)[9] to capture any archives that might not be current members of any of the above. By the same token I even carried out a Google search using the search terms 'archives' and 'hospital'. In order to maximize the comprehensiveness of my data set, finally, I searched a number of hospital websites for the Public Relations unit as the most likely office or authority to have knowledge of archival holdings, specifically photographs.

Most important, I made extensive use of my personal network of archivists. In fact, this network goes well beyond the narrow circle of healthcare archivists, and my discussions with colleagues at many different types of institutions not only offered me much valuable advice on the new survey but also led me to recognize what appears to be an oversight that is fundamental and near-universal at once. While it is well established that many decades' worth of hospital archives have at

[6] Association of Canadian Archivists: www.archivists.ca (last accessed 19 March 2013).
[7] Coalition of Canadian Healthcare Museums and Archives: www.cchma.ca (last accessed 19 March 2013).
[8] See for example the Association for Manitoba Archives, www.mbarchives.ca (last accessed 19 March 2013).
[9] Archives Canada: www.archivescanada.ca (last accessed 19 March 2013).

various times been deposited with public archives at the municipal and provincial levels, there appears to exist no clear link in either direction between the originating archives (and of course the creator departments) and the depository archives.

Securing the Responses

Once I had assembled the detailed contact information in the form of telephone numbers, mail and e-mail addresses for each institution in my sample, I made a concerted effort to call each individual so identified within a period of two days. Introducing myself and my thesis project, I asked to whom the survey should be sent. In cases where it came up, I also identified myself as the Archivist at the Health Sciences Centre in Winnipeg. I found that in all cases the individual contacted was incredibly helpful and interested in the survey. Occasionally I was put through to the Corporate Office to discuss if the institution had an archives, and in one case to the Privacy Office; only once was I asked how the data was to be used. This fits with discussions I have had in a professional capacity, in which I was told that hospitals quite often survey each other so that this procedure would not be foreign or unusual to them.

For a few institutions, unfortunately, I was unable, despite my best efforts, to ascertain the name and contact information for the person or office I was hoping to identify; in these cases, therefore, I had sent the questionnaires by mail to the Communications Department.

Having tracked the responses over a month, I then carried out some follow-up calls to those institutions that had not yet responded. In this case I contacted the same individuals to whom I had originally sent the survey, but even this only met with limited success.

Concerning the medium (paper vs. e-mail) of the survey questionnaires, my initial thought had been that, given the likely age group of the respondents, they might be more inclined to respond to a paper questionnaire rather than to an electronic survey. In fact, as the calls progressed it quickly became clear that this was not the case, and in many instances there was a request for an e-copy over a paper one, which was duly sent. But this caused an additional problem: it meant that I lost control over who the actual respondents might turn out to be. In one particular case, an individual helpfully sent my questionnaire to another whom I had already contacted, yielding two questionnaires with different identification numbers for the same institution.

The Responses

The vast majority of the responses were obtained within a four-week period; a couple of stragglers replied shortly thereafter. The response rate by province is given in Table 4.

Table 4: Response Rate by Province

PROVINCE	NUMBER OF QUESTIONNAIRES SENT	NUMBER OF QUESTIONNAIRES RETURNED
British Columbia	4	1
Alberta	7	3
Saskatchewan	2	1
Manitoba	3	2
Ontario	18	14
Quebec	19	9
New Brunswick	4	–
Nova Scotia	2	–
Newfoundland and Labrador	1	1
Canada	60	31

As noted above, even the number of questionnaires sent out was very small for some provinces, where university-level institutions are few and far between and a smaller population base makes for hospitals with a smaller bed capacity ratio. The results of the survey may well also reflect the fact that many such institutions have undergone massive reorganizations in recent years, and that the effects of such global changes have resulted in obscuring the identities of the constituent members and, very likely, even the existence and location of their corporate archives.

It is interesting to compare the responses between provinces. British Columbia and Alberta, for example, both have highly centralized healthcare systems, and yet it seems remarkable that only a single response was received from the four institutions in British Columbia that met the survey criteria. In Alberta, similarly, even though seven questionnaires were sent out, they actually ended up in the hands of only two individuals. This strikingly reflects the pervasive centralization in the administration of healthcare institutions in the province of Alberta. In Manitoba, another centralized system of Regional Health Authorities, it was gratifying to see that of the three sent out, two were returned, with clear answers. The number of hospital archives in the province of Ontario is extremely high, as is their response rate: the overall number of 18 institutions that met the criteria to be included in the survey accounts for the remarkably high number of 14 responses. While a direct causal link cannot, of course, be demonstrated, it is tempting to speculate that this may well be due to the untiring efforts of Barbara L. Craig and her students and colleagues. For the province of Quebec, too, 9 out of 19 represents a remarkable response rate – and this despite the fact that the questionnaire was, for practical reasons, sent only in English. That the response rate for Quebec is lower than that for Ontario may, of course, also reflect fundamental differences in organizational structures.

In view of the very small number of university-level healthcare institutions in the Maritime Provinces, it is all the more regrettable that the one response received was, in fact, an empty response. In consequence, unfortunately, this region is, in effect, excluded from the discussion which follows.

While several responses were, in effect, returned empty and others left many questions unanswered, it should not go without mention that some responses stood out by their thoroughness. For example:

> We will photocopy or scan small quantities of records, chiefly photos, for internal staff and the public free of charge. Access to records is provided to internal staff, and access to the public is considered on a case by case basis. Generally, access to recent records, i.e. post 1980, requires permission of the creating department. We can give permission for use of photos for which [the Authority] holds the copyright. We have a page on the [Authority] intranet that provides information to staff on the Archives holdings and services, as well as institutional histories and a selection of photos from the collection. We provide copies of School of Nursing transcripts to the graduate for a fee.

> Privacy is a great issue in health care archives and does limit access to some records that are not strictly patient records. For instance, we cannot post photos of patients online. In [this province] we are governed by [two acts concerning the protection of health information and privacy respectively]. Privacy in our Region is under the purview of Risk Management, and we can get advice from them if necessary.

Another example:

> Medical Records and the [Hospital] Archive share an off-site storage facility for inactive records awaiting destruction and for storage of some of the [hospital] archive. I work with Medical Records, moving and shelving boxes, arranging for destruction, etc. I also wrote an omnibus [Hospital] records retention schedule that includes Medical Records and assist in surveying backlogs of all [Hospital] records when needed and seek authorization for appropriate action from most responsible offices [including Medical Records].

Despite the readily listed and acknowledged drawbacks of an open-ended survey, it is one of its most obvious and most valuable advantages that the respondents feel encouraged to provide substantive comments on issues that are important to them.

Finally, while 31 questionnaires were in fact returned, representing an overall response rate above 50%, of that number only 20 questionnaires were actually completed. The other 11 were returned blank, with the respondent making use of the 'empty-return' box provided on the first page of the questionnaire (see Appendix B). This means that the actual response rate was 33.3% and that the analysis is based on a third of the institutions that were contacted. In the analysis of the individual questions, the number of respondents out of 20 is given as not all respondents answered all questions.

The Questionnaire

The new assessment of the corporate archives of Canadian hospitals was conducted as part of the current thesis project in the spring of 2013. The consent form and the questionnaire are given in full as Appendices A and B, respectively.

The survey asked respondents if their facility had an archives, when it was established, if there had ever been an archives, and if there was a written history of the institution. It then asked where the archives was positioned within the corporate structure and what its relationship was to other corporate areas of the institution. It also asked about staff positions and funding. It further dealt with archival issues more narrowly defined, including what types of records were held, what privacy issues were encountered, and the nature of their user groups. Finally, it attempted to address the complex problem of e-records, which had not yet become much of an issue at the time of the earlier ACA survey (1979).

The most obvious outcome of the survey, as predicted, is the empirical observation that the proportion of Canadian healthcare institutions with corporate archives is still quite small.

The results in the tables that follow are given to one decimal point, thus they do not necessarily add up to exactly 100%. This is due to the method of rounding used.

Analysis

Question 1. Does your Health Care Facility have an administrative / corporate / business archives that is distinct from patient records?

Of the sample of 20 hospital archives, 19 responded to this question. The results are set out in the table below.

Table 5: Hospitals with Distinct Corporate Archives

Response	N	%
Yes	18	95.0
No	1	5.0
Total	19	100

These results show that 95% of the institutions surveyed make a clear distinction between administrative/corporate/business archives and patient records. Four of the affirmative respondents provided additional details regarding the manner in which their archives were managed as separate entities from patient records. One respondent specifically indicated that their archives were categorized as corporate. One respondent stated that their records were "an integral part of the Records Management program." One stated that their archives were a mix of historic and administrative records. A fourth respondent stated that their archives were separate

from patient records and were held by a third party "along with the Faculty of Health Sciences Archives."

These results confirm findings in the literature that a distinction between patient records and administrative/corporate/business records exists within the organizations sampled.

Question 2. If yes, when was it established?

Of the sample of 20 hospital archives, 16 responded to this question. The results are set out in the table below.

Table 6: Dates of Establishment of Hospital Archives

Response	N	%
Before 1970	0	0
1970 – 1979	2	12.5
1980 – 1989	5	31.2
1990 – 1999	4	25.0
2000 – 2009	5	31.2
2010 – 2013	0	0
Total	16	100

These results show that the creation of currently and recently existing Canadian hospital archives occurred between 1974 and 2009 with a peak in the 1980s. It is interesting to note that this movement began in 1974, a year before the founding of the Association for Canadian Archivists. It is a matter of speculation if this is pure coincidence or if it indicates changes that were occurring in the Canadian archival scene in general. Another point of note is that two of the five that were established between 1980 and 1989 have similar starting patterns, beginning with Archives or Museum Committees and becoming more formalized in the 1990s.

It is striking that within the last three years preceding the 2013 survey not a single archives had been created, raising the question of a cause: is the absence of new archives related to the general global economic crisis, a lack of funding for archives at a national level (especially with the cancellation of programs such as the Hannah Institute and National Archival Development Program) or perhaps only a lack of centenaries that might have evoked the special interest on the part of the institutions required for such an act.

These results confirm findings in the literature that there has been an interest in the establishment of healthcare archives from the 1970s onwards and that there was a concerted effort in the 1980s to establish healthcare archives in response to discussion in both the archival and the healthcare literature (see Chapter 2).

Question 3. If no, was there an archives previously?
From_____ to _____ (dates)
Why was it closed?
Where have the holdings been deposited?

Of the sample of 20 hospital archives, only 4 responded to these questions.

The results show that of the four archives responding to this question, three appear to have been closed and all of these between 2012 and 2013. As reasons for closing the respondents cited budget cuts and space requirements. In one case the records appear to still be on site (although this is unclear) while in the other case the records are offsite in a records storage facility rather than in an archives facility. The third respondent did not specify the reasons for the closure or the subsequent location of the holdings. The answers of the fourth respondent, too, were not clear. They explained that the institution did not have formally established archives, and that the corporate office continued to keep their own records. Against this background, they also explained that, while their early records had been transferred to their mother house (they were originally administered as a religious hospital), some archival records have been maintained by the hospital since the 1960s.

These results confirm that, as anticipated, archives in general and more specifically archives in the healthcare sector are permanently in a state of flux. They are not only subject to budget and space constraints and dependent on external

funding opportunities but, in addition, they are beholden to the whims of senior administrators who may or may not choose to see the value of an archives.

Question 4. Is there a written history of your institution?

Of the sample of 20 hospital archives, 19 responded to this question. The results are set out in the table below.

Table 7: Hospitals with a Written History

Response	N	%
Yes	13	68.4
No	5	26.3
Unknown	1	5.3
Total	19	100

These results show that 68% of the respondents have a written history of their hospital. Of the five that answered no, one noted that a book was in process and scheduled to be published in 2016.

These results suggest that there is a definite correlation between the existence of an archives and the publication of a history of a healthcare institution. However, it is impossible from these results to determine which came first, the archives or the

book. Archives in general are often set up in response to the collection of materials for an anniversary or celebration that results in a book or some other publication. Once the book is published or the celebration concluded there is a question of what to do with the materials that have been donated in good faith.

Question (4) is followed by a request for elaboration in Question (4a), seeking further details regarding written histories.

Question 4a. If it is published, please provide the details:

Of the sample of 20 hospital archives, 14 responded to this question. The results are set out in the table below.

In many cases there was more than one publication; in some instances this reflected the fact that the current institution has come about through the amalgamation of various hospitals, each with its own proud tradition. This led to results showing a higher number of published dates than there were respondents.

Table 8: Publication Dates of Hospital Histories

Response	N
Before 1970	1
1970 – 1979	4
1980 – 1989	3
1990 – 1999	4
2000 – 2009	6
2010 – 2013	1
In progress	1
No details	3
Total	23

These results show that there is a fairly steady number of published works between 1970 and 1999 with a slight spike in the period from 2000 to 2009 which could either be 'centennial fever' for individual institutions, 'millennial fever' or perhaps just ease of printing with digital technology.

These results suggest that there might be a more direct correlation between the existence of an archives and the publication of histories. Comparing these results with results from Question (2) (Table 6: Dates of Establishment of Hospital Archives by Decade) it could be suggested that either a straight comparison by decade (e.g.,

2000 – 2009) or across decades (e.g., 1970 – 1979 versus 1980 – 1989) yields the suggestion of a correlation. Between 2000 and 2009 five archives were established and six books were published, while a comparison of 1970s to 1980s shows two archives established in the 1970s and three books published in the 1980s.

Although the question asked for details, I have only listed the date of publication since the titles would violate the anonymity of my respondents. Unfortunately, in three instances (listed here as 'no details') the respondent noted that there were publications but did not provide either the title or a publication date.

Question 5. Where is your archives located in the overall organizational structure of your institution?

Of the sample of 20 hospital archives, 15 responded to this question. The results are set out in the table below.

Table 9: Reporting Location of the Archives

Response	N	%
Administration	7	46.6
Library	4	26.6
Volunteers	2	13.0
Foundation	1	6.6
Not formal	1	6.6
Total	15	100

These results show that although the location of the archives was varied it was generally at a fairly high level within the organizational structure, with 46% of the institutions surveyed locating their archives within the Administration. Of the 46%, three had close links to a department dealing with legal issues (Mission, Ethics & Spirituality; Legal & Privacy; Privacy Office). The second largest group (26%) were those that had a close link with the Library, and the final notable group showed a link to the Volunteer Departments with 13% of the respondents.

These results further confirm the results of Question (1), showing the existence of a distinct administrative/corporate/business archives. The location of the archives within the Administration, which is indicated by the results of Question (5), asking about reporting structure, illustrates the emphasis placed on the value of the

archives by the institution. The location in conjunction with the Library and with Volunteer Departments may be a legacy of the archives being initiated in or by these units; in the case of the Library it may also reflect a desire to locate archives with the most closely related unit.

Question 6. What is the relationship of the archives to other branches of your institution:

Medical Records
Library
Foundation
Alumni Association
Corporate Office
Public Relations
Records Management
Information Technology

Of the sample of 20 hospital archives, 17 responded to this question. The frequency of the relationships with each branch identified in the survey is set out in the table below.

Table 10: Relationship to other Branches of the Institution

Response	Frequency identified	% of archives (N= to 17)
Corporate Office	11	64.7
Public Relations	10	58.8
Library	9	52.9
Records Management	9	52.9
Information Technology	9	52.9
Foundation	8	47.0
Alumni Association	8	47.0
Medical Records	5	29.4

These results show that 65% of the respondents had a relationship with (a) the Corporate Office, the archives receiving records from them and providing reference services to them. Taking these percentages in conjunction with those of Question (5) (Table 9), concerning reporting structure (where Administration was seen to be 46%), we can conclude that the connection between the archives and the corporate office of an institution is very strong in the majority of cases.

59% of the respondents had a relationship with (b) Public Relations. The archivist provides material for publication (e.g., in newsletters and the like) in addition to receiving records and providing reference services. This can be seen in the

statement from one respondent that "from time to time the archivist publishes articles, contests, photos etc. in the staff newsletter." Another respondent stated that they "Work together on some projects – share material."

The next set of branches with which they had a relationship was (c) Library, Records Management and Information Technology; 53% of the respondents had a relationship with each of these three units. These results are especially interesting since two of these three professions, Library and Records Management, are generally viewed as closely allied to the archives while archivists also tend to recognize a need to work closely with the third, Information Technology.

The relationship with (d) Foundation and Alumni Association shows a total of 47% each. However, the relationship with Alumni tends to be fairly close. It was noted more than once by the respondents that alumnae/alumni records and artifacts were housed in the collections and that their alumnae members helped out in answering questions and serving on committees. There was, however, no such annotation included with reference to a relationship with the individual foundations.

It is significant that only 29% of the respondents indicated any relationship with (e) Medical Records, and in these cases the relationship is either with this department as a client group to whom the archives provides reference services

(without receiving access to patient records) or, in two instances, as a unit with whom the archives shares storage space.

These results indicate that the responses fall into five groups: (a) Corporate Office; (b) Public Relations; (c) Library, Records Management and Information Technology; (d) Foundation and Alumni Association; (e) Medical Records. Of the seventeen responses, eleven (65%) had a relationship with Corporate Office; this was followed by Public Relations with ten (59%) occurrences.

Note that the list of units was based on my own experience at two different healthcare facilities. In some cases I thought that an archives may have come out of one of these other branches or that they may have regular contact with some of them in day-to-day affairs. I also already knew that at least one of the archives I was surveying had a very close relationship with the Hospital Foundation, and another had a close relationship with their Library Services.

The results confirm that, as expected, a high proportion of archives have a relationship with the Corporate Office (versus a low number with Medical Records). These results also confirm what can be seen in Table 5 regarding the distinction between the Corporate Office and Medical Records and in Table 9 with respect to the reporting structure within the organizational structure.

The strength of these various relationships may have consequences for the stability, and perhaps even the continued existence, of an archives program. The fact that the vast majority of the respondents indicated a strong relationship with the Corporate Office (and, as we will see, a heavy reliance on this part of the institution) suggests that they are very much dependent on that branch for their funding.

Question 7. How many staff positions (FTE) does your archives have?

Of the sample of 20 hospital archives, 18 responded to this question. The results are set out in the table below.

Table 11: Staff Positions

Response	N	%
No staff positions	6	33.3
Less than full-time staff	6	33.3
1 full-time staff	4	22.2
2 – 5 full-time staff	2	11.1
6 – 10 full-time staff	0	0
More than 10 full-time staff	0	0
Total	18	100

These results show that two thirds (67%) of the respondents either have no staff at all or have some staff, but only on a part-time basis. This is followed by 22% of institutions having one full-time staff member and 11% of institutions having between 2 and 5 full-time staff. No institution has more than five full-time staff members. This may indicate budget constraints on the part of either the archives or the institution but may also show a factor that is something of a trend in some parts of healthcare – that of part-time employment and therefore flexible work hours.

Often archives are initially established by volunteers and run by them for some time, their presence often being a legacy of how things were begun, and they often continue to support the archives even once paid staff is put in place. The existence of paid staff versus volunteers is also potentially an indicator of the relevance that the hospital places on the archives – whether they are willing to find funding to hire a professional or make do with volunteers. In times of budgetary constraints for archives, volunteers are a source of labour that helps with what is often a vast, unprocessed backlog; volunteers can also bring additional knowledge as they have an interest in the history of health and/or a particular healthcare facility.

The next two questions, (7a) and (7b), ask for details about staffing.

Question 7a. How many of them are volunteers?

Of the sample of 20 hospital archives, 16 responded to this question. The results are set out in the table below.

Table 12: Volunteers

Response	N	%
No volunteers	9	56.2
1 – 5 volunteers	5	31.2
6 – 10 volunteers	2	12.5
More than 10 volunteers	0	0
Total	16	100

These results show that, contrary to expectation, 56% of these archives do not have any form of volunteer assistance, while the second largest category, with a result of 31%, consists of archives that have a low number of volunteers (from one to five volunteers). Interestingly, in the two cases where there are more than five volunteers, the number of these helpers is seven. One wonders if this is coincidence or if it may be a matter of space, computer access and other administrative factors, e.g., how many of the volunteers have some form of training and how much time a part-time staff member may have to supervise volunteers.

Of the 33% who reported in reply to Question 7 (Table 11) that they had no staff, a third had volunteers, another third reported no volunteers, and a third did not answer. It is not clear how an archives can exist, much less function, without any staff or volunteers, though the archives may of course be "run off the side of the desk" by someone whose main responsibility is unrelated to the archives. However, this was not specified in the answers and is a matter of speculation.

The next question, (7b), seeks further information about the professional training of archival staff.

Question 7b. What are their training and certification levels in archival studies?

Of the sample of 20 hospital archives, 15 responded to this question. The results are set out in the table below.

Table 13: Types of Qualification

Response	N	%
University	11	73.3
College	1	6.6
Provincial course	1	6.6
Other (certificate)	1	6.6
None	1	6.6
Total	15	100

These results show that in 73% of cases the staff have an advanced degree (Master in Archival Studies; Master in Museum Studies; Master in Library Science with Archives Specialization; Master in Information Studies; Master in Library and Information Studies; Librarian; Master of Arts in Public History; Baccalauréat) while other types of training are represented only minimally. This shows that while the institution may not be in a position to pay for a full-time staff member, they value the archives enough to staff it with someone with the appropriate qualifications. This may also be a reflection of the fact that the institutions surveyed had a teaching affiliation with a university and therefore may feel that credentials are a necessary part of any staff appointment they make.

These results indicate that the institution sees level of training as an important aspect of the staffing of the archives and that there is an expectation of a more formalized, post-graduate qualification for staff positions.

Question 8. What types of funding does your archives have?

Of the sample of 20 hospital archives, 17 responded to this question. Two of these responses indicated no funding and these responses were analyzed separately. The results are set out in the table below and are calculated based on 15 respondents, not 17.

Table 14: Types of Funding

Response	Frequency identified	% of archives (N= to 15)
Fully funded by hospital	6	40.0
Partially funded by hospital	6	40.0
Fully grant-funded	0	0
Partially grant-funded	5	33.3
Fully funded by foundation	0	0
Partially funded by foundation	2	13.3
Donations	1	6.6

These results show that 40% of the archives surveyed are fully funded by the hospital while 60% are dependent on mixed funding. The most frequently identified source of mixed funding is the hospital, followed by grants and the foundations.

80% of the archives surveyed were funded either completely or partially by the hospital. This funding was provided either directly or through the budget line of another department to whom the archives reports (in three cases the Library and one with the Volunteer Department budget). This dependence on hospital funding is precarious because the archives budget line, as all archivists are painfully aware, is an easy one to slash when funding becomes tight.

Other sources of funding, however, are even more precarious. This can be seen in the results where 33% of the respondents indicated a fairly heavy reliance on grants for at least a percentage of their funding. Given that grants rarely provide full funding, but rather have to be matched by the institution (e.g., in the federal government's "Young Canada Works" program), it shows that the parent bodies have a vested interest in keeping their archives afloat (albeit on a shoestring budget).

Of the two that did not receive any funding, one is not a formally established archives, but the other appears to exist without either funding or staff; my reading of this case is that the archives is part of a larger department and the work is done on an *ad hoc* basis when the staff member has time.

The results show that a good percentage of funding is provided by the parent body, a fact which documents an institutional recognition of the value of its archives.

Question 9. What are the proportions of the various types of funding (e.g., 60% foundations, 10% provincial government, 50% grants, etc.)?

Of the sample of 20 hospital archives, 8 responded to this question but offered a total of 10 responses. A lower response rate and a lack of clear data meant that it was impossible to analyze the responses accurately. What the responses did show was a significant dependence on hospital funding and various levels of grant and foundation funding consistent with the results from the previous question.

The results of Question (8) and Question (9) taken together show that funding, or lack thereof, is a key element in the existence of any program, and archives are no different. However, the funding opportunities for archives are extremely limited, and this situation was aggravated by the cancellation of the National Archival Development Program and the cancellation of archives funding by the Hannah Institute. In the meantime, however, the major hospitals of Canada continue to have archives for which they themselves provide the lion's share of funding.

There is also evidence, when comparing these results with those from Questions (5) and (6), whose results showed a close correlation between the reporting relationship and a 'use' relationship, that once again there is a close link between the archives and their corporate funding body.

Question 10. What types of records do you hold?

Of the sample of 20 hospital archives, 9 responded to this question. The results are set out in the table below.

Table 15: Types of Records Held

Response	Frequency identified	% of archives (N=to 9)
Administrative records	8	88.8
Still and moving images	6	66.6
School of Nursing records	3	33.3
Drawings(architectural/engineering)	2	22.2
Alumni records	2	22.2
Newsletters	2	22.2
Human Resources files	1	11.1
Oral history	1	11.1

These results show that 88% (8 out of 9) of the types of records held are corporate records of an administrative nature, including minutes of various high-level bodies (e.g., Board of Directors, Medical Advisory Committee, and the like). This indicates, as expected, that most institutions recognize the value of these records irrespective of their legal obligation to retain them, and thereby also the importance of an archive that will preserve and protect these records for future reference.

Not surprisingly, the survey provided a significantly enlarged – and thus much more representative – list of the types of records preserved in the corporate archives of Canadian healthcare institutions. If nothing else, hospital archives generally hold

records pertaining to the high-level running of the institution; they typically encompass a broad range of record types, from board minutes and annual reports to legal contracts and a variety of fiscal records (where the scale may run from multi-year budget plans down to individual invoices and receipts). In addition, they often include records documenting the relationship of the institution to the outside world (the public face of a hospital) such as newsletters, news releases and publicity materials – including photographs that may be either spontaneous or staged.

Table 15 shows that 33% of the responding archives hold School of Nursing records and 22% hold records created by the Alumnae/Alumni Association of a School of Nursing. This was not as high as anticipated. The literature had indicated that one type of record typically found in Canadian healthcare institutions is that concerning the establishment and development of Schools of Nursing run by the hospitals and their alumnae/alumni associations. Both groups in my experience create and hold not only substantial amounts of records but also special collections (textbooks, professional journals, biographies, etc.) and various artifacts (instruments, uniforms, badges, etc.). It appears that these records may have become scattered when Schools of Nursing closed.

The following three question deal with non-paper records.

Question 10a. Do you have museum artifacts? (e.g., uniforms, instruments, etc.)

Of the sample of 20 hospital archives, 18 responded to this question. The results are set out in the table below.

Table 16: Hospital Archives Holding Artifacts

Response	N	%
Yes	16	89.0
No	2	11.1
Total	18	100

These results show that 89% of the institutions surveyed have museum artifacts. However, in two of these cases the number of artifacts is small, the majority having been transferred to a museum rather than being held by the archives. The remaining 11% stated that they did not have artifacts. Unfortunately the question of why they do not have artifacts was not asked, but it can be surmised that it is related to a lack of space as much as a lack of a mandate or a lack of items.

These results confirm findings in the literature that archives within healthcare facilities generally accept artifacts into their collections as well as textual records.

The final two questions, about electronic records, were intended to elicit a response that would indicate, on an empirical basis, if the archives community in Canadian healthcare institutions is handling the transition to electronic records any better than their colleagues in the rest of the archival community, since they are presumably exposed to fairly sophisticated models in the neighbouring fields of electronic medical records as well as to other moves towards a more digital environment within the teaching and practice of medicine.

Question 10b. How do you handle electronic records (e.g. email, photographs, videos, policy manuals)?

Of the sample of 20 hospital archives, 17 responded to this question. However, the question they answered was evidently the yes/no question, "**Do you** handle electronic records?", rather than the content question, "**How** do you handle electronic records?", which appeared on the questionnaire. They were presumably misled into this reading of (10b) since the questions preceding and following it were yes/no questions of the form, "Do you (etc.)".

Taking the question as it was answered, rather than how it was intended, we find that, like their colleagues in other archives, healthcare archivists are struggling with this issue. The results are set out in the table below.

Table 17: Hospital Archives Handling Electronic Records

Response	N	%
Yes	12	70.5
No	5	29.4
Total	17	100

These results show that while 70% of the respondents handle some electronic records, comments such as "TBD – ongoing project," "essentially we remain at an exploratory stage," and "The hospital is currently considering options for either a centralized electronic archive or a more formal decentralized archive" show that archival work in this area is still very much in its infancy.

The next question asks for details on more narrowly defined types of electronic records.

Question 10c. Do you accept born digital and/or digitized records?

Of the sample of 20 hospital archives, 17 responded to this question. The results are set out in the table below.

Table 18: Hospital Archives Accepting Born Digital and/or Digitized Records

Response	**N**	%
Yes	11	64.7
No	6	33.2
Total	17	100

These results show that 65% of the institutions surveyed accept born digital and/or digitized records. In four cases the respondent answered the question with an explanation indicating that the issue was definitely on their radar but that they were limited in what they could accept. Comments included "Could accept but very limited capacity to preserve digital records," "Not on a large scale. We are in a holding pattern until decisions about the management of born digital records are made," "We would accept digital records but do not have any yet," and "[name] Archives does accept born digital and digitized records."

In other cases the respondents suggest a definite move towards a positive answer with comments such as "The hospital is moving towards a fully digital/electronic records environment. It is to be determined how these information holdings will be managed in future, particularly how they will be managed corporately (in a centralized manner)" and "Policy to come."

It seems reasonable to expect that the environment in which healthcare archives are situated, given the prominence of electronic medical records and the presence of a strong IT team, provides them with a supportive infrastructure for this type of work. That said, this question did not ask about the percentage of records they were receiving in an electronic format or the space constraints that they may run into as they move further into this field. The strong relationship with Information Technology that is reported in 53% of cases in Table 10 would seem to bode well for a smooth transition to accepting or continuing to accept born digital and/or digitized records.

Question 11. What are the major privacy issues you encounter?

Of the sample of 20 hospital archives, 16 responded to this question. The results are set out in the table below.

Table 19: Hospitals that have Encountered Privacy Issues

Response	N	%
Yes	10	62.5
No	6	37.5
Total	16	100

These results show that 62% of the institutions surveyed had encountered major privacy issues. In five of those cases there was reference to concern over images that might be used to identify a patient. This concern was documented across the country and is in all likelihood related to an expansive interpretation of the legislation whereby any photograph showing a patient potentially violates personal health information law as it shows that a specific individual was in a healthcare facility, and therefore presumably receiving healthcare, at a given time.

In three of the 62% the concerns were more about access to and loss of records in general. In two cases of the 62% there were concerns about personal information in general, as can be seen from the comment "Person Info" with respect to those enrolled in the School of Nursing long since closed. Many inquiries are from family members tracing history; handful of inquiries from someone wanted to locate a classmate" and "Personal info; some personal health info; some confidential corporate records."

Turning to the respondents who answered in the negative, in five of the 37% the answer was a straightforward "No". It was only in one case that the answer was qualified:

> None as yet. External researchers wishing to access anything other than public domain materials are required to apply to the [Name] University Health Sciences Research Ethics Board for approval prior

> to research. The Archive also has a researcher agreement, copyright agreement forms, and we are developing a few structure for certain services. For internal requests the archivist undertakes these searches for the requestors. As yet [name] Hospital has not fielded an Access to Information request that involves [name] Hospital archival material.

It can therefore be seen that in the majority of cases the archives have encountered major privacy issues which they have had to consider and deal with.

These results confirm that with various privacy acts that apply to healthcare institutions coming into force, this has become a major issue for healthcare archives. In fact, the issue of personal information relates not only to patients but also to staff. It is a national issue and the concerns are the same across the country even though health and the legislation surrounding it are generally provincial in scope.

Question 12. Who are the major types of users?

Facility staff

Students, faculty, research staff, etc.

Administrative staff (e.g., publicity staff)

Public (genealogists, historians, etc.)

Of the sample of 20 hospital archives, 17 responded to this question. The results are set out in the table below.

Table 20: Types of Users of Hospital Archives

Response	Frequency identified	% of archives (N= to 17)
Administrative staff	14	82.3
Public (genealogists, historians, etc.)	13	76.4
Students, faculty, research staff, etc.	12	70.5

These results show that 82% of the respondents identified noted that their users were administrative staff. 70% were "Students, faculty, research staff" and 76% were "Public." External researchers of various kinds cover everything from medical researchers, history of medicine students, high school students and alumnae to genealogists, writers, publishers and TV producers. Many of the answers to this question were extensively annotated.

These results indicate that, while the archives generally enjoy a close relationship with the corporate bodies of their institution (and therefore might well be regarded as a corporate repository), there is evidently a great interest in their holdings on the part of non-corporate users. It is possible that this might be influencing other factors such as funding and even placement of the archives within the institution. To the extent that archives function as a corporate service, the vast majority of their users are internal. Given the social emphasis of healthcare archives and the social nature of

hospitals, it is not surprising that such archives also attract a large percentage of users from outside.

Question 13. What types of technical/support services do you provide?

a. Reading room (regular hours of service or by appointment only)

Of the sample of 20 hospital archives, 16 responded to this question. The results are set out in the table below.

Table 21: Hospital Archives Providing a Reading Room

Response	N	%
Yes	15	93.7
No	1	6.2
Total	16	100

These results show that 93% of the institutions surveyed indicated that they provided a reading room. Of the 93%, eight archives required or recommended an appointment to use the collections; since the vast majority of the archivists only hold part-time positions, the need for users to make an appointment may be due partly to the availability of staff and also to the volume of work an archivist may have at any given time.

The final question concerns permission required for using the archives and its services.

Question 13. What types of technical/support services do you provide?
b. Permissions (access, publications etc.), photocopy/scanning services

Of the sample of 20 hospital archives, 14 responded to this question. The results are set out in the table below.

Table 22: Hospital Archives Providing Services

Response	N	%
Yes	13	92.8
No	1	7.1
Total	14	100

These results show that 93% of the institutions surveyed provided permissions. Their answers ranged from a straight "Yes" in five cases, a short answer in the affirmative in another five cases (e.g., "Can be arranged"), and an annotated yes in three cases.

It appears that photocopying and/or scanning is available, and is sometimes fee driven, while access to records depends on the prospective user's status as an

external or internal client. In keeping with a corporate archives mentality, access for external researchers is considered on a case by case basis, especially with respect to records that are less than 30 years old, and external researchers must submit a formal research agreement. In some cases the archivist may even conduct research for both internal and external clients. In addition, permissions for publication are overseen by the archivist, and at least in one case a fee schedule for services was being developed at the time of the survey.

Summary

It is not in the least surprising, both as a general principle and, especially, in view of the experimental nature of this survey, that the empirical data collected in the 2013 survey are robust in some areas and less than clear in others. It is particularly unfortunate that the restricted scope of this survey, and the limited responses from some provinces, did not permit the analysis of regional differences.

The summary review presented here draws on the most reliable evidence available, with occasional illustrations or incidental observations added where appropriate. The order in which the various topics are discussed in this summary differs from the sequence of the questions in the survey instrument. Beginning with the "constitutional" issues of (a) the status of the corporate archives, (b) their location in the organizational structure of Canada's healthcare institutions and (c) the types of records they typically hold, we next discuss fiscal matters such as (d) funding, (e)

staffing, and the important findings of the survey with respect to (f) the academic qualifications of healthcare archivists. The largely diagnostic questions of (g) published histories and (h) types of users, followed by more practical matters such as (i) the inclusion of artifacts and (j) the provision of user services, ultimately lead to the pressing issues of (k) electronic records and (l) privacy legislation.

In the course of the past three decades almost every healthcare institution in Canada has experienced at least one wave of reorganization, usually in the form of amalgamation (though occasionally also by its reversal). It would go beyond the scope of this study to delineate the various stages of these processes in detail, and it would be difficult without further investigation to determine how many historically identifiable hospitals and their archives are actually represented by the current institutions whose structures are here surveyed.

A significant proportion of these hospitals (a) have corporate archives. The dates at which these archives were established range from 1974 to 2011, with recognizable clusters in the last two decades of the twentieth century and in the first decade of the twenty-first. Given the long recorded history of some of these institutions, it should be noted that the current corporate archives are not always a direct continuation of the historical collections, which are typically held under the auspices of a religious order and may be preserved at the order's mother house. The

survey also recorded the closing of two archives in 2012: one had been in operation since the early 1950s, the other since 1987.

The location of these archives in their respective organizational structures (b) is remarkably consistent: they all ultimately report at the vice-presidential level. While the particular terms vary from "Vice-President Mission and Ethics" to "Organizational Engagement," two of them are institutionally linked to cognate departments: either the library (under "Knowledge and Technology") or the records management department (under "Legal and Privacy").

The close relationship between the corporate archives and records management is noteworthy in its own right. However, from my own experience as the archivist of an Ontario hospital I was surprised to discover that, despite the efforts of the Ontario Hospital Association in the 1980s in creating a records retention schedule for corporate records, which was revised in 2006 in consultation with the Archives Association of Ontario's *Health Archives Interest Group*, there still appears to be no close link, in 2013, between records management and the corporate archives in healthcare facilities in Ontario.

The survey documents a clear cluster of linkages between the corporate archives and the corporate offices, the public relations establishment, and the alumnae/alumni association. The association between the archives and the library is

unremarkable, as is the relationship between the archives and information technology. None of the respondents reports a link between the archives and medical records. In one instance, in fact, the respondent explicitly states that they were "distinct."

The types of records (c) held by hospital archives normally pertain to the high-level running of the institution; they tend to encompass a broad range of record types, from board minutes and annual reports to legal contracts and a variety of fiscal records.

With respect to (d) funding, institutional support is prevalent though often precarious; only special projects are grant-driven. This state of affairs seems to point to the scarcity of relevant grant programs.

The staffing picture (e), while initially appearing bleak, does in fact show that over half the respondents have archives that are staffed, albeit sometimes only by a part-time person.

The academic qualifications of archivists (f) are high. With one exception, all professional archivists hold an advanced degree or diploma in their field.

The existence of (g) a published history of the institution coincides almost entirely with the existence of a corporate archives, suggesting a link between these

two factors in the formation of institutional identity. The same pattern is reflected in the types of users (h), where the senior administration and corporate staff in general constitute the major clients; in addition, there is also the expected use by students, faculty and other research staff on the one hand and by members of the public on the other.

Museum artifacts (i) are a standard part of many healthcare archives. Access and (j) user services vary, with the different levels of access and services presumably related above all to staffing levels.

The integration of electronic records (k) into archival collections seems halting and piecemeal. Aside from the occasional photograph, the treatment of large-scale sets of e-mail correspondence and of larger documents as well as other categories of born digital material evidently constitutes a challenge for the corporate archives of Canadian healthcare institutions in the coming years.

Privacy issues (l) are a major and on-going challenge for all healthcare archives in Canada but the details differ from province to province, reflecting not only the provincial character of personal health information legislation but also, it appears, the existence of a strong and unified body of healthcare archivists in Ontario. The responses from that province are remarkably consistent with respect to privacy issues; this may well be due to the strenuous efforts of Carolyn Heald (then

Information Policy Advisor at the Archives of Ontario) in ensuring that archival issues were explicitly addressed in the Regulations to the Personal Health Information Protection Act (PHIPA) of 2004.

Finally, in recapitulating the key findings of the 2013 survey of healthcare archives in Canada, we would stress that these corporate archives are universally distinct from the medical records departments, that they are typically located fairly high in the organizational structure, and that they are always funded institutionally (with grants normally limited to supporting special projects).

CONCLUSION

THE CASE FOR IMPROVEMENTS

It is the basic argument of this thesis that the value of corporate archives of Canadian hospitals in preserving the records of these institutions is beyond doubt. In addition to their practical importance for reference and legal questions, these administrative records also permit hospitals to assert their institutional identity and their central position in the community.

We began by reviewing the history of the modern hospital as it was buffeted by rapid progress in the natural sciences and equally sudden and massive changes in the socio-economic structures in which it is embedded, ultimately resulting in the general hospital serving as the almost universal healthcare provider for rich and poor alike. We next examined the gradual emergence, interrupted by frequent pauses and problems, of the notion of corporate or administrative archives for Canadian hospitals. In order to illustrate these developments and the challenges faced by hospital administrators and archivists alike, we presented case studies of the Kingston General Hospital, of the hospital scene in Calgary and, most comprehensively, of the

Winnipeg General Hospital and the Health Sciences Centre, Winnipeg, as its successor. Finally, we conducted and analyzed a limited but systematic survey of hospital archives across Canada.

The emergence of the hospital "as a quintessentially modern institution," in Charles Rosenberg's words, promising the latest medical treatment supported by every technical innovation, took place in a first major step between 1870 and 1920; at the same time, moreover, the hospital "had become central to the education and practice of a much larger proportion of the profession."[1] Over the following half century, a second major step rendered the Canadian hospital open to all by the increasing participation of government both in direct subsidies and in the provision of universal healthcare insurance. In the course of the century from 1870 to 1970, the leaders of society running the governing boards of most hospitals, who "felt a personal responsibility for every aspect of the institution and regularly inspected its wards,"[2] had given way to a managerial class whose members felt as expert in their work as the medical professionals did in theirs. This new breed of bureaucrats also produced a vastly greater amount of records.

If archivists or historians expected to find these major changes, and especially the historical ruptures between their several phases, reflected more or less directly in

[1] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), pp. 7, 346.
[2] Ibid., p. 338.

the archival record, the review conducted of the archival literature and the case studies undertaken in three distinct settings suggest that they will be disappointed. There is, to be sure, a gradual increase in the amount of records turned over to the archives but no evidence for abrupt changes in the types of records. Above all, there is no measurable change in the proportion of records to have survived.

The neglect of hospital records and archives in Canada is all the more striking in view of the fact that the records created in and by healthcare institutions are inherently important. From the perspective of the archivist, the case made mainly in the 1980s and 1990s for the value of corporate archives in hospitals seems to have had some effect on the state of hospital archives, but not a major impact. While there are now more of these archives than before the 1980s, on the whole the hospital archives sector remains underdeveloped. By examining the current state of such archives and of hospital thinking in this domain I hope to have shown that a renewed case ought to be made to create and maintain them.

There is of course considerable diversity among the types, holdings, and uses of these archives, but overall they suffer neglect and require renewed support from the corporate leaders of the healthcare institutions. Aside from their contributions to the identity and social purpose of the hospital, their holdings will probably play an increasingly important part in litigation; moreover, most of the holdings of the twenty-first century are likely to exist in the fragile and vulnerable form of digital

records. The renewed case for hospital archives may therefore well take shape around these emerging concerns.

In suggesting changes that could be made to enhance the functioning of hospital archives and their long-term value to the institutions of which they form a part, we put the highest priority on improving the cooperation between the hospital archives and the records management program. In many respects, these two can be viewed as two sides of the same coin, and the general recognition that is presumably being accorded to records management programs by most hospital administrators should make it easier to convince them to extend the same priority to hospital archives.

At the same time, senior administrators need to be alerted to the fact that the corporate record collections of hospitals which have at various times been deposited in municipal or provincial archives need to be re-associated, either physically or by cross-referencing between catalogues, with the institution that created them.

We also should not neglect the cumulative effect of various practical steps that might be taken to boost the visibility of hospital archives, including outreach to the whole community and especially current and retired staff, the establishment of a dedicated endowment fund to make the archives self-sustaining, and the identification

of high-level players within the institution who recognize the value of an active archives.

A fundamental trait of corporate archives that, I believe, has not been sufficiently recognized until now is the fact that many of the larger reports they preserve are typically written by teams rather than individual authors. Thus, they may not evoke the emotional stance (tinged with vanity) that creators normally develop towards their work. As a consequence, as Fiorella Foscarini points out in her recent ACA conference paper, corporate archives do not benefit from the emotional attachment and support of personal authors.[3] If teams responsible for documents could be encouraged to take personal responsibility, this would not only lighten the task of cataloguing their work but also increase the chance of having it preserved – and successfully retrieved – in the archives.

In reviewing the 2013 survey we observe first of all that a number of corporate archives actually exist in Canadian Acute Care (General) Healthcare Facilities and that the reporting structures under which they work are for the most part highly functional. Their institutional funding, on the other hand, tends to be sorely deficient – as, of course, it is for all archives.

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[3] Fiorella Foscarini, "Exploring Notions of Community and Genre: Who is In? Who it Out?," ACA Annual Conference, Winnipeg, June 2013; this observation is explored and more fully documented in Anne Beaufort, "Writing in the Professions," in Charles Bazerman (Ed.), *Handbook of Research on Writing: History, Society, School, Individual, Text* (New York: Lawrence Erlbaum Associates, 2008), pp. 221-235.

A major initiative arising from the 2013 survey is the suggestion for a full-scale survey to bring the ACA survey of 1979 up to date and to document the current status of corporate archives in all Canadian healthcare facilities rather than just the subset surveyed here. This initiative should clearly have the highest priority over the next few years in the activities and plans of the Association of Canadian Archivists. In addition it would be useful to see an informal (and less expensive) network that will also have a crucial role in shoring up existing archives and supporting emerging corporate archives.

In the meantime, it is encouraging to note that even a modest undertaking such as the 2013 survey has already led to a great deal of informal correspondence and activity devoted to these goals. Indeed, in addition to its academic interest, the survey also seems to have had a much more immediately practical result: two of the respondents have begun a lively correspondence with the explicitly stated aim of using the results of this survey in actually setting up formal hospital archives.

Concerning the long-term outlook for corporate archives in Canadian hospitals, the most urgent requirement is for those who have long recognized the importance of these archives – archivists, historians and other researchers – to join forces with hospital administrators. Above all, it will have to be the collective

experts that provide the senior administrators with the arguments they need in order to persuade the various government bodies of the enduring value of the archival record.

APPENDIX A

2013 SURVEY: CONSENT FORM

CONSENT FORM: Survey of Administrative Archives in Canadian Health Care Facilities

sent by: Emma Prescott, M.A., M.L.I.S. (Master's Student, Archival Studies Program, Department of History, University of Manitoba)

Please return to: Emma Prescott, 842 Holly Ave, Winnipeg, Manitoba R3T 1W4, ecpresco@shaw.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask.

Research Project Title:

Acute Condition? An Exploration of the Status of Administrative Archival Records in Canadian Acute-Care Hospitals with Teaching Affiliations

Principal Investigator:

Emma Prescott, M.A., M.L.I.S. (Master's Student, Archival Studies Program, Department of History, University of Manitoba)

Research Supervisor:

Professor Thomas Nesmith, Department of History, University of Manitoba, Winnipeg R3T 5V5, tel: 204-474-8559, email: nesmith@cc.umanitoba.ca

This project examines the status of the administrative records and archives held by Canadian health care facilities (or, for short, hospitals). These archives are generally overlooked, yet such corporate records constitute an integral aspect of the institutional position of hospitals in the community.

Hospital archives generally hold records pertaining to the high-level running of the institution. In addition to board minutes and annual reports, these often include records documenting the relationship of the institution to the outside world (the public face of a hospital) such as newsletters and publicity materials. (Corporate records of this type are, of course, entirely distinct from patient records and medical records in the narrow sense.)

The **purpose** of this study is to establish the extent to which corporate records of Canadian healthcare facilities (more specifically, acute care facilities with teaching affiliation) are maintained either in formally distinct archives or in various less formal ways.

The **procedure** for this study is for a single questionnaire of about 20 items to be sent to approximately 40 acute care facilities with teaching affiliation across Canada.

The **benefits** of this study will be to provide all respondents with a sense that the record-keeping practices at healthcare facilities may not be uniform; a summary report will be sent to all participants once the project is completed.

The data collected in this study will by anonymous. Once the individual responses have been acknowledged, they will be treated as anonymous, with the identity of the respondent to be known only to the Principal Researcher. All responses and correspondence will be destroyed once the project is completed.

Potential respondents may withdraw from this study by simply not returning the questionnaire.

The results of the survey will be available in the completed thesis, which will be available on MSpace and through Library and Archives Canada.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued

participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Joint Faculty Research Ethics Board of the University of Manitoba and the University of Winnipeg. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

APPENDIX B

2013 SURVEY: QUESTIONNAIRE

SURVEY FORM: Survey of Administrative Archives in Canadian Health Care Facilities

sent by: Emma Prescott, M.A., M.L.I.S. (Master's Student, Archival Studies Program, Department of History, University of Manitoba)

Please return to: Emma Prescott, 842 Holly Ave, Winnipeg, Manitoba R3T 1W4, ecpresco@shaw.ca

Please feel free to ignore questions that may not apply to your institution.

If you don't want to fill out any part of this survey please check here ☐ and send this page back to me.

Additional comments and extra sheets are welcome!

THANK YOU.

Part A: EXTERNAL HISTORY

1. Does your Health Care Facility have an administrative/corporate/business archives that is distinct from patient records?
2. If yes, when was it established?
3. If no, was there an archives previously?
    a. From_____ to _____ (dates)
    b. Why was it closed?
    c. Where have the holdings been deposited?
4. Is there a written history of your institution?
    a. If it is published, please provide the details:

Part B: STRUCTURAL ISSUES

5. Where is your archives located in the overall organizational structure of your institution?
6. What is the relationship of the archives to other branches of your institution:
    a. Medical Records
    b. Library
    c. Foundation
    d. Alumni Association
    e. Corporate Office
    f. Public Relations
    g. Records Management
    h. Information Technology
7. How many staff positions (FTE) does your archives have?
    a. How many of them are volunteers?
    b. What are their training and certification levels in archival studies?
8. What types of funding does your archives have?
9. What are the proportions of the various types of funding (e.g., 60% foundations, 10% provincial government, 50% grants, etc.)?

Part C: ARCHIVAL ISSUES

10. What types of records do you hold?
    a. Do you have museum artefacts? (e.g., uniforms, instruments, etc.)
    b. How do you handle electronic records (e.g., email, photographs, videos, policy manuals)?
    c. Do you accept born digital and/or digitized records?
11. What are the major privacy issues you encounter?
12. Who are the major types of users?
    a. Facility staff
        i. Students, faculty, research staff, etc.
        ii. Administrative staff (e.g., publicity staff)
    b. Public (genealogists, historians, etc.)
13. What types of technical/support services do you provide?
    a. Reading room (regular hours of service or by appointment only)
    b. Permissions (access, publications etc.), photocopy/scanning services

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