PARTING AT THE CROSSROADS: THE DEVELOPMENT OF EDUCATION FOR PSYCHIATRIC NURSING IN THREE CANADIAN PROVINCES, 1909-1955

by

Veryl Margaret Tipliski

A dissertation
submitted to the Faculty of Graduate Studies,
University of Manitoba in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

Winnipeg, Manitoba
December, 2002

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

PARTING AT THE CROSSROADS: THE DEVELOPMENT OF EDUCATION FOR PSYCHIATRIC NURSING IN THREE CANADIAN PROVINCES 1909-1955

BY

VERYL MARGARET TIPLISKI

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

of

Doctor of Philosophy

Chapter 5

A Critical Shortage of Mental Hospital Nurses Drives Education for Psychiatric Nursing in Three Neighbouring Provinces, 1940-1949

Introduction

By the end of the Second World War provincial mental hospitals in Saskatchewan, Manitoba and Ontario were in the midst of a crisis involving too many patients and a severe shortage of trained nurses to care for those patients. This chapter shows that the varied approaches taken by the key players to ameliorate the mental hospital nursing shortage influenced the development of education for psychiatric nursing in each of these provinces.

This chapter begins with an overview of Canadian psychiatric care during the war and early post-war years, focusing on the deteriorated conditions of Canada's mental hospitals and the shortage of trained nurses. The chapter is organized thematically and geographically. Beginning with Saskatchewan and then moving eastward to Manitoba and Ontario, this chapter shows how the nursing shortage drove psychiatric nurse training in each of these provinces. Including the cases for all three provinces is enlightening. These provinces were geographic neighbours dealing with the same dearth of trained mental hospital nurses throughout the 1940's. However, the approaches taken within each province by organized nursing, the provincial governments and medical psychiatry around this shortage varied dramatically. This chapter examines the intricate relations

amongst these key players in their attempts to control psychiatric nursing education. It argues that their success or failure in the quest to control education for psychiatric nursing resulted in the varied models which arose across the three provinces and even within one province. It shows that in contrast to the uniform models which developed in the United States and Britain, education for psychiatric nursing did not develop as one seamless model across the boundaries of these provinces.

Included with each provincial case are memoirs of five retired nurses who were mental hospital students during the 1940's. They were participants in the education which organized nursing, governments and medical psychiatry endeavored to control. This chapter shows that while the models of education varied, from the perspective of the retired nurses there was a striking similarity in their training school experiences.

An Overview of Canadian Psychiatric Care during the War and Early Post-War Years

During the Second World War medical psychiatry, or as it was termed by the Royal Canadian Army Medical Corps (RCAMC), neuropsychiatry, was increasingly accepted by the public and the medical profession.[1] Ten percent of all recruits for the Canadian Armed Forces who were screened by psychiatrists had to be rejected for mental health reasons and thousands more were treated by psychiatrists both abroad and at home following their discharge. As in the First World War shell shock (war neurosis) or conversion hysteria was a common problem along with other anxiety disorders, somatic symptoms, alcoholism and neurosyphilis.[2] The public came to realize that war-induced stress had the potential to induce mental health problems in people just like themselves. In Basingstoke, England a 200 bed facility named the Number 1 Neurological Hospital

was established by the Canadian government and administered by neuropsychiatrists from the Montreal Neurological Institute and the neuropsychiatry unit at the Toronto General Hospital. Although psychiatrists from provincial mental hospitals across Canada also trained and served at this mental health facility, most of its registered nurses were recruited from the two neuropsychiatry facilities in Montreal and Toronto.[3] The RCAMC advocated an integrated medical approach to psychiatric problems rather than the custodial mental hospital model, again enhancing medical psychiatry's wider post-war acceptance and status.[4]

Provincial mental hospitals, already financially starved by their governments during the Depression, continued to be underfunded and overcrowded. They experienced a variety of staffing problems, most often a lack of trained female staff and physicians.[5] Just as he did following the First World War, Dr. Clarence Hincks of the CNCMH surveyed mental hospital facilities throughout the country and notified the health ministers about these concerns:

> There has been a remarkable awakening of genuine interest in mental health as a result of experiences in the armed services during the world conflict. The mental hospital situation in Canada has reached an intersection and a critical point. The stage is set for far-reaching mental health progress but we cannot move forward without trained personnel. There is a dearth of trained mental health personnel in the Dominion and a paucity of professionals in the field.[6]

Psychiatrists also perceived a post-war turning point. They wished to continue bridging the gap between mental and physical health care and general hospitals. Many saw no future for themselves at the provincial mental hospitals and instead wished to practise in general hospital psychiatry. But in order for psychiatrists to leave the mental hospitals,

governments first needed to be convinced of psychiatry's importance to overall health care and the need to enhance spending on this specialty.[7]

As described in this chapter, organized nursing in each of the three provinces dealt with the need for mental hospital nurses in a different manner. A letter from the principal of McGill University, sent to Canada's health ministers, described how his university was attempting to help with the shortage:

> A new one year post-graduate course in psychiatric nursing has been established at the McGill School for Graduate Nurses. It should meet a great need throughout Canada in the preparation of nurses who will become supervisors in the rapidly expanding field of Psychiatric Nursing. It will serve to prepare nurses to take part in the building up of programmes in Psychiatric Nursing for post-graduate and undergraduate nursing education which are being demanded with increasing urgency throughout the whole country...[8]

However, post-war awakenings and turning points made little difference to the realities of the provincial mental hospital scene. From 1945 to the end of the decade conditions deteriorated even further, and for the first time the Canadian public read about provincial mental hospitals in their daily newspapers and weekly magazines. Don Le Bourdais, former director of education for the CNCMH and journalist, wrote a series of articles which described the conditions of Canada's mental hospitals:

> From Halifax to Vancouver I have just finished a trip of 8000 miles to see how we are treating more than 50,000 fellow Canadians held behind the locked doors and barred windows of our 30 odd provincial mental hospitals. I found that more than 50,000 sick people are jammed into wards that would be overcrowded with 35,000. Since the beginning of the depression and before–governments have been starving mental hospitals. Almost no building has been done. Not only are the hospitals overcrowded, they are also understaffed. And given overcrowding and understaffing, anything can happen–assault, violence and death. You can't get more than you pay for and the average amount spent on a patient is little more than a dollar a day. In general hospitals the cost is from three to six dollars a day while prisoners cost two dollars daily.[9]

The superintendent of nurses of the Saskatchewan mental hospital at Weyburn took us to a ward of 180 women, the strangest collection of women to be seen in Canada. Some stand as if rooted to their spot, others wander aimlessly and others lie upon the floor. Sickly white faces, some saliva-slobbered and smeared with filth, bedraggled, not one of these women is decently dressed. Some wear only a heavy cotton shirt hanging like a bag–others wear nothing. Yet once they were as other women, once they took pride in looking their best, once they were someone's wives, mothers and sisters. Now they are lost, the end result of 20 years of neglect. It is a disgrace that any human being in this so-called civilized land should live as they do. This ward is singled out as the most overcrowded of any that I visited in Canada. But the present Saskatchewan government cannot be blamed as it has been in power for only two years. At the present it is not a lack of finances that stands in the way but the lack of trained staff and building material. Saskatchewan has not had adequate mental hospital nurse training schools and must now pay the penalty of that neglect.[10]

The Brandon mental hospital women's pavilion contained 196 patients, many disturbed and violent. Except for two graduate nurses and six nurses' aides the staff consisted of untrained girls. More than the usual amount of restraint was in use–18 were in camisoles and 18 in solitary confinement. Dr. Stuart Schultz was surprised when I told him that the camisole has been abolished in most hospitals....The chief problem is that most governments in Canada and the Manitoba government in particular do not realize the seriousness of the situation. At Brandon the building program consists of a 50 bed addition for 1948. Ten such units would not be enough. Overcrowded and poorly staffed, it is more a matter of luck than good management that no disaster has occurred in any of the western Canada mental hospitals. One of the great bugbears of mental hospital management is the increasing number of elderly senile patients who occupy the time of nurses. Years ago there were few old people in western Canada....[11]

In Ontario the Hon. Russell Kelley, new Minister of Health refused to let me visit his hospitals. I have been informed that the staff morale is low. They are packed with 16,000 patients–3,000 more than they can comfortably hold and are dangerously short of doctors and graduate nurses. Most buildings are over 100 years old...imagine the plumbing. The excuse of course, as with all other governments, is the war. But these conditions existed before the war. The war only accentuated a bad situation.[12]

It is obvious that governments must spend much more than they do in caring for the mentally ill. Some provinces cannot afford to spend any more and the difference should be made up out of the federal

> treasury...probably will not do so until there is a demand from the people themselves for treatment for these patients, no matter in what province they may reside.[13]

This series of articles was enough to send a shudder through the country. In Manitoba the articles provoked a debate in the provincial legislature, with Ivan Schultz, Minister of Health pointing out that the Weyburn, Saskatchewan mental hospital was worse than those in Manitoba.[14] In Saskatchewan Dr. Donald McKerracher, new Commissioner of Mental Health Services, told a newspaper reporter that his government had already begun working on solving the problems noted in the series.[15] And for the first time the status of Canada's mental hospitals came to the attention of the House of Commons.[16]

There was not a federal government health and welfare department established until 1944, and although the provincial health ministers had discussed mental health funding issues with the federal government through the war years and immediately afterwards, the federal government played no direct role. That began to change with the appointments of Dr. Charles Stogdill as chief of the health department's new mental health division, and Elsie Ogilvie, RN, to survey the provincial mental hospitals in relation to staff shortages. In 1948 the federal government introduced the National Health Grants Program and designated the largest grant to provincial mental health care, but it took until the next decade before mental hospital patients saw much change in their care.[17]

While journalist Don Le Bourdais' articles provided a detailed description of the status of mental hospitals in each province, he only briefly noted mental hospital nursing and training. Beginning with Saskatchewan and then moving to Manitoba and lastly, Ontario, the following parts of this chapter show how the shortage of mental hospital

nurses drove education for psychiatric nursing in each of these provinces throughout the 1940's. Included with each provincial case are the memoirs of retired mental hospital nurses. These nurses were students at three provincial mental hospitals during the war or early post-war years. Their viewpoints provided an insider look and a fuller understanding of what mental hospital training was about.

The Saskatchewan Government Creates a New Nursing Profession

Twenty-Five Years Behind Ontario

In the summer of 1938 Dr. James MacNeill, Medical Superintendent of the (North) Battleford Mental Hospital and Commissioner of Mental Hospital Services for Saskatchewan initiated communication with Dr. Bernard McGhie, Deputy Minister of Health for Ontario, on the topic of affiliation between mental and general hospitals. He explained:

> It has not been possible up until now to have this hospital affiliated with a general hospital and the matter has now come up for consideration. I would like to know how it is done...send me a copy of Ontario regulations.[18]

There were a few factors which led to MacNeill's letter of inquiry. For several months MacNeill and his colleague Dr. A. Campbell, Medical Superintendent of the Weyburn Mental Hospital, had been disagreeing about the need for registered nurses at the Weyburn institution. Campbell and his assistant were undertaking more medical procedures – metrazol shock, insulin coma and heat cabinet fever treatments, and needed trained nurses. However, Dr. MacNeill, as Commissioner of Mental Services, controlled staffing for both of the Saskatchewan institutions, and did not believe that registered

nurses should be hired into these special nursing positions.[19] He considered that registered nurses and his mental hospital female nurse-attendants were one and the same, as far as educational preparation was concerned. Clearly frustrated, Campbell suggested that registered nurses hired for the Saskatchewan mental hospitals should not be called nurse-attendants and should start at a higher salary than untrained nurse-attendants.[20] Dr. MacNeill exerted his authority in a letter to Campbell:

> I am absolutely opposed to placing registered nurses in charge of wards just because they are RN's. They must have psychiatric training first. It is my belief that graduate nurses must be trained on the wards not less than one year and take our lectures in psychiatry before being given this responsibility. You cannot take registered nurses off the street and put them in charge of something they know nothing about.[21]

MacNeill had been closed to the idea of registered nurses working at his two hospitals for some time, and even his own matron of nurses was not a nurse.[22] Needless to say, he was unhappy with some of the comments made by Dr. George Weir in his report on the status of nursing education and practise in Canada. Weir did not consider that mental hospital attendants were the same as nurses and called for general training schools to incorporate psychiatric nursing into the basic curriculum.[23] MacNeill set the direction for Saskatchewan when commenting on this report to Dr. Campbell:

> The report which Dr. Weir makes with regard to hospitals getting cheap help and then turning out that quality of individual on the country is not very flattering to us. As you know the training which pupils get in general hospitals–anatomy, physiology with a smattering of materia medica is not of much value when you come to deal with psychological problems. I am going to be discussing the matter with Dr. Weir. We are dealing with disorders of emotion, not physical diseases....I am of the belief that the care of mental patients has got to be worked out from the inside. In other words, psychiatry has got to save its own soul.[24]

When Weir's report was published in 1932 Drs. MacNeill and Campbell had just initiated a two-year lecture course for male attendants and female nurse-attendants at

the North Battleford and Weyburn mental hospitals. There had not been any training offered prior to 1930 and that this training came about was related to a report done on Saskatchewan's mental hospitals by the Canadian National Committee on Mental Hygiene (CNCMH). Premier J. Anderson's new Progressive Conservative Government was concerned about overcrowding at the two institutions and asked Dr. Clarence Hincks to direct a review. There were about 1,000 patients at each facility. North Battleford employed thirty-three nurse-attendants, seventy-five male attendants and one registered nurse. There was a fully equipped operating room. Marjorie Keyes accompanied Hincks and her nursing background was evident in these recommendations:

1. Begin a training school to ensure the instruction of the nursing force in psychology, psychiatry and medicine.
2. All nurses should be graduates of a mental hospital training school or registered nurses with mental hospital experience or enrolled in the proposed school.
3. Change the status of male attendants so that eventually all can be male nurses or orderlies. In general the training of male nurses is not to be encouraged. The bulk of nursing duties should devolve upon women.[25]

And so it was that the two medical superintendents began lectures in psychiatry to their male and female attendants. Although the Saskatchewan government conferred a diploma in mental nursing at the end of two years, it was based on about fifty hours of lectures and not the nurse training envisioned by Marjorie Keyes and Hincks.[26] The graduates were sometimes referred to as graduate attendants but almost never as mental nurses. Dr. Campbell's request for registered nurses to assist with the increased emphasis on medical treatments pointed to the need for more training, and in 1937 one year was added. Although the curriculum differed between the two hospitals there was an increased emphasis on nursing skills and procedures and the whole program involved about one hundred hours of classes and final examinations.[27] Attendants and nurse-

attendants were required to take some introductory lectures but it was optional as to whether they took the full three-year one hundred hour program.[28]

Although the CNCMH report suggested discouraging males from nurse training, Dr. MacNeill did not heed this advice. In Saskatchewan, male attendants and nurse-attendants were of equal status and the training was available to all who wished to attend lectures. MacNeill's beliefs about training males were clear:

> It is my belief that males should be as well qualified to take care of mental patients as the female staff. While a great deal has been stressed about female nurses in mental hospitals, the time has not arrived, and the time, in my judgement never will arrive when you can do without men taking care of male patients in mental hospitals. I have looked over a large number of mental hospitals in Eastern Canada and the United States, where they have been training female nurses for years, and the percentage of male attendants taking care of male patients is as large as ever. In my judgement the only way to cope with this situation is to give these men training and pay them a salary to make it worth their while to continue in the business as a profession, and at the end of their usefulness, to give them a pension on which they could live comfortably for the rest of their days.[29]

MacNeill clearly had patient care in mind but his thinking about the importance of nurse training schools in "hospitalizing" the mental hospitals differed from that found among mental hospital superintendents in both Ontario and Manitoba. In those provinces the superintendents' goal was to train enough female nurses to care for both female and male patients, as was the case in general hospitals.[30]

With the three year mental nurse training program for his staff underway, Dr. MacNeill believed his pupils were ready to begin affiliating to general hospitals, but it was Kathleen Ellis' three day visit to the North Battleford Mental Hospital which caused him to write to Ontario's Dr. McGhie for advice.[31]

Kathleen Ellis had studied at Columbia University's Teacher's College after leaving the Winnipeg General Hospital in 1935 and following graduation, obtained the

student advisor/registrar position with the Saskatchewan Registered Nurses' Association (SRNA). Within a year she was invited to organize and direct the University of Saskatchewan's (UofS) first school of nursing and so combined both roles. The SRNA administered its own registration Act but the UofS was responsible for registration examinations and it was a convenient arrangement for Ellis.[32]

When Ellis arrived in Saskatchewan in 1937 there was only a handful of registered nurses working at the province's two mental hospitals and one small psychopathic ward at the Regina General Hospital. The school of nursing at the latter hospital had an affiliation arrangement with the psychopathic ward but it did not involve all student nurses. There were no post-graduate courses in psychiatric nursing in Saskatchewan, and because Dr. MacNeill preferred not to hire registered nurses, even the economic Depression did not create an influx of registered nurses to the two institutions as occurred in Manitoba and Ontario.[33] Weyburn's Dr. Campbell heard from many registered nurses who were interested, but his hands were tied.[34] Ellis believed that it was essential to get general hospital student nurses affiliating to the mental hospitals and initiated discussions with MacNeill during a May, 1938 visit to the North Battleford Mental Hospital.[35] The only previous time that mental hospital nursing had been on the SRNA council agenda was in 1923 when questions were raised about this new branch of nursing and the association's responsibility.[36]

The Battleford or North Battleford Mental Hospital was built in a beautiful location overlooking the North Saskatchewan and Battle Rivers three miles south of North Battleford. It opened in 1914 when Saskatchewan's mental patients, temporarily housed at Brandon's mental hospital, were returned by train. Dr. James MacNeill, a

McGill University medical school graduate and member of the Saskatchewan legislature, was appointed by his Liberal Government as the hospital's first superintendent. Although he was not a psychiatrist, MacNeill traveled to the Phipps Clinic at Johns Hopkins and the Rockwood Hospital for the Insane in Kingston for guidance. Within a few years the hospital plant consisted of the main building, powerhouse, laundry, farm buildings, warehouse, gardens, grain fields, orchards, livestock, poultry, staff apartment building, nurses' home, staff homes, curling rink, amusement hall, greenhouses, and golf course. The hospital was spread over 2,500 acres and was so self-contained that a school for the children of hospital staff was established and the CNR ran a rail line into the complex. Many of the hospital's first attendants were Great War veterans who remained on staff until they retired. Through the years it was common for several generations of the same family to find employment at the hospital. As was common in all provincial mental hospitals, the majority of patients at North Battleford were patient labourers. A separate farm and accommodation was built for about 300 patients who helped with farming.[37]

Saskatchewan's Liberal Government allowed MacNeill full reign, and with his autocratic and paternalistic style, many staff became dependent upon him. He was both loved and hated.[38] Even when the Anderson Progressive Conservative Government came to power in 1929 there was no move to replace him. Instead, he was also given the new position of Commissioner of Mental Services for the province.[39]

The Battleford Mental Hospital served the whole province until crowding forced the construction of a second facility 400 miles south at Weyburn. Both institutions were located long distances from the province's two main urban centres, Saskatoon and Regina. A 1937 newspaper article reported that there were 500 patients too many at each

mental hospital and that the government was being urged to build another institution whenever the economy improved. The article described some wards at the Battleford facility where the beds were pushed so close together that patients were unable to sit on the edges of their beds. The reporter was not critical; in fact he thought the hospital looked just like a country club.[40] As was often the case with Saskatchewan's mental hospital situation, authoritarian but still gracious and socially refined medical superintendents somehow impressed outsiders with exaggerations. It became difficult to separate fact from fiction and there were few who challenged these physicians and the myths which they perpetuated.

Ellis' report to the SRNA council described her impressions of the North Battleford Mental Hospital and the training:

> The purpose of the visit was to make contacts and to ascertain whether existing conditions offer possibilities favourable for affiliation. There are about 1,500 patients. In spite of overcrowded conditions the hospital seemed to be efficiently administered. The superintendent of nursing is not a nurse. She was formerly a school teacher. There are six graduate nurses and eighty students who are required to spend three years in the institution before receiving certificates. Classes are not admitted but vacancies are filled as they arise. The entrance requirements call for grade eleven. The students receive a salary of $725.00 to $830.00 per annum. The class of persons employed seemed on the whole, very good. The accommodation and nurses' home are pleasing. The teaching is carried out by the physicians and a graduate nurse. It includes a limited number of lectures and except for psychiatry, clinical experience is limited. The lack of someone with adequate preparation to direct the teaching was evident. The officials seemed interested in the question of affiliation and were desirous of a plan for reciprocal affiliation. Although many adjustments would be necessary, it is the opinion of the Registrar that the situation offers definite and desirable possibilities. Without making any commitment, a copy of the *Proposed Curriculum for Schools of Nursing in Canada* was forwarded.[41]

With the report in hand the SRNA council, although interested in considering reciprocal affiliations, directed Ellis to continue studying the "question of affiliation".[42]

Information was gathered from Alberta, British Columbia and Ontario as to how general hospital schools were affiliating with provincial mental hospitals. Ellis found that this was a recent development, with Ontario being the most advanced in obtaining mental hospital affiliations.[43] As for the mental to general hospital affiliation, Ellis thought that the one year experience required in Ontario for registration was too short and was more satisfied with the two year requirement at Alberta's Ponoka Mental Hospital.[44] This background information was used by the SRNA council to develop four principles to guide future plans for reciprocal affiliations:

1. General hospital students should be required to spend a minimum of two months in a mental hospital affiliation.
2. A fully qualified instructor with general hospital training and specialized experience in psychiatry should be on the mental hospital staff to teach affiliating students.
3. For students from mental hospitals seeking affiliation with general hospitals for the purpose of registration, the required term should be two years. The students would have to meet the entrance requirements of the school extending the affiliation.
4. An interchange of salaries would not be feasible.[45]

Ellis had assistance gathering the information and it is not known if she was aware that the mental hospital schools in Ontario were approved by the RNAO and inspected by the government, whereas the Ponoka training school in Alberta had no formal relationship with the Alberta Association of Registered Nurses.[46]

Dr. MacNeill's information-gathering was limited to his communication with Dr. McGhie in Ontario who advised:

> You should be able to bring some pressure on the nursing profession to give nurse training in your mental hospitals and if necessary, general training to obtain their RN. We have found that those who begin their training in mental hospitals and take their general affiliation later in the course are better nurses for mental patients than those nurses who do the post-graduate course in mental nursing later. I should think you would be able to bring enough pressure on your nurse education council in

> Saskatchewan and on the general hospitals with training schools (as you pay grants to the general hospitals) to bring about this very desirable training arrangement.[47]

McGhie belonged to the school of psychiatrists who subscribed to Nettie Fidler's description that nurses "must be reared in the mental hospital".[48] No doubt McGhie's comment about general hospital trained nurses reinforced MacNeill's already negative perception but he was puzzled about these items:

> 1. What salary do you start your nurse-attendants without any training?
> 2. What arrangements do you make about the nurse-attendant's salary when she is putting in her time in a general hospital? We have nurse-attendants here who are very anxious to get their RN but do not wish to lose any seniority.[49]

McGhie's response clarified the great differences in mental hospital training between the two provinces:

> Our students in training are first taken on for five months probation and they receive a ten dollar honorarium each month. If they pass their examinations at the end of five months they receive twenty-five dollars a month allowance and perquisites. They are not civil servants until they receive their RN and apply to come on staff. During their year affiliation the allowance is discontinued. I can see that your situation is very different from ours. None of our student nurses were ever attendants, but were high school graduates and came into the training schools with a view of becoming RNs. Some twenty-five years ago the hospitals in Ontario went through the same situation you are facing now.[50]

It was unfortunate that Ellis herself never had this information about the Ontario mental hospital training program. The knowledge that Saskatchewan was a generation behind in training mental nurses was powerful and could have been utilized in her negotiations with MacNeill. Miss Hazel Jacques, Lady Superintendent, outlined the North Battleford Mental Hospital's response to the SRNA's four principles:

> After a great deal of consultation we have arrived at the following conclusions on affiliation:

1. Mental hospital students shall be required to spend two years in the home school and eighteen months in a general hospital.
2. General hospital students shall be required to spend nine or twelve months on a mental hospital affiliation. If the SRNA council feels that two months is all the time available, it might be advisable to arrange post-graduate work in mental nursing. It takes medical men two or three years to become a psychiatrist. Two months would not enable the nurse to obtain her Diploma in Mental Nursing. Twelve months would be preferable and nine months is Essential. Owing to the fact that there are as many beds in mental hospitals as in general hospitals and that from 50 – 75% of all patients consulting medical practitioners are mental cases, it should be kept in mind that mental hospital work might develop into a special and distinct profession. Then instead of affiliations, post-graduate work would have to be arranged. Were it not for the fact that our nurse-attendants have limited practical experience in surgical and communicable diseases nursing, they could take their place in the nursing field in any capacity.[51]

North Battleford Mental Hospital officials were clearly offended by the SRNA's principles for affiliations and were not about to let the SRNA leadership exert any authority over the length of affiliations with their institution. They perceived that their graduates were as well-trained as general hospital graduates. The notice that their work could evolve into a separate profession was most likely based on information obtained by Dr. MacNeill on visits to Britain and from some male attendants who emigrated from Britain where mental nurses had a separate registry.[52] A surprised Ellis attempted to clarify the SNRA's goals for the mental hospital affiliation:

> The idea is not to qualify general students as specialists or to entitle them to a specialty certificate but to give them insight into this branch of nursing to impress upon them its value and application in all types of nursing. You will see by referring to the CNA's Proposed Curriculum (forwarded to you) such a course is based on recommendations from the CNCMH. In the provinces where affiliations take place, the length varies from Ontario (3 months), Alberta (1 month) and British Columbia (2 months). In a general hospital with a Psychopathic Department, the usual affiliation is 2 months. Re-the length of affiliation recommended for your students, I am sure this will be given every consideration by SRNA council.[53]

Ellis invited Dr. MacNeill and Miss Jacques to meet with the Council in January, 1939 but two staff psychiatrists from North Battlefield and Weyburn attended instead. The minutes reported that plans for reciprocal affiliations were discussed and points were clarified. Ellis was requested to forward sample examinations to the North Battleford Mental Hospital in order to determine "the extent to which the pupils were prepared to affiliate at general hospitals".[54] According to Ellis, with the outbreak of the Second World War later that year and her subsequent involvement with the emergency, there was no further communication from MacNeill or Jacques. Her perception was that the length of affiliation for general students remained an issue for MacNeill.[55]

Like all of Canada's mental hospitals, the Battleford Mental Hospital became even more overcrowded during the war years and experienced a depletion of staff. By 1944 there were almost 1,700 patients, about 200 more than in 1939.[56] The number of attendants and nurse-attendants who had graduated from the hospital training course dropped from 111 to 58, while the number of untrained caregivers rose from 100 to 215. Many of the untrained staff were older, while some were young men who for personal reasons objected to joining the military effort. There was a rapid turnover among the untrained staff and little commitment to providing patient care. There were times when one nurse-attendant was responsible for over one hundred patients.[57] Conditions were so severe that Saskatchewan's deputy health minister advised the federal government that the province required financial assistance in order to provide psychiatric care to mentally ill Saskatchewan men in the Canadian military. He highlighted these points:

> We are lacking in bed capacity. The financial aspect of the problem is holding us back...without capital expenditures for the past ten years. We have an excess of 50% over our bed capacity, which does not lend itself to adequate treatment of patients from the service forces who may require

> mental hospital care. It would not be advisable to admit such young soldier patients, breaking down in this war, into such institutions...attended by elderly attendants who would not have the necessary knowledge of the newer methods of treatment.[58]

In spite of this reality Dr. Davison was offended when he was advised that the province's two mental hospitals could not be included on the Canadian Medical Association's approval list for internships and residencies. He presented the myth that Saskatchewan's mental hospitals were no worse than those found in other provinces.[59]

The Second World War also brought challenges to Saskatchewan's registered nurses. Ellis was appointed to the Canadian Nurses' Association (CNA) as the association's emergency nursing advisor. Much of her position involved working with the CNA and federal government on nurse recruitment and maintenance through management of the government's grant to the association.[60] During the war, the shortage of registered nurses in Saskatchewan became worse year by year. Throughout the country there was increased demand for and mobility of nurses with rural areas hit especially hard. The SRNA with the help of the CNA grant was able to maintain its recruitment of students to the province's eleven schools of nursing, thereby lessening the overall impact of the shortage. Nevertheless there were only 1,000 registered nurses practising in the province by war's end. The province was short 500 registered nurses. Rural hospitals, sanatoria and mental hospitals experienced a marked shortage. There were no post-graduate courses for specialty nursing, teaching or administration, meaning nurses were required to leave the province and often never returned. Few nurses moved to the province.[61]

Laying the Groundwork

Premier Tommy Clement Douglas (T.C. Douglas) and his Co-operative Commonwealth Federation Government (CCF) came to power in Saskatchewan in summer 1944, drawing much of its support from a farmer-worker alliance.[62] For the first time the province's mental hospital attendants and nurse-attendants were allowed to organize and bargain collectively, and joined the United Civil Servants of Canada (UCSC), a union affiliated with the Canadian Congress of Labour (CCL). The CCL struck an agreement with the new government, winning bargaining rights for all mental hospital employees; and in the process the new hospital union, Local Three, exposed examples of intimidation and political patronage carried out by Dr. MacNeill and others in positions of authority at the Battleford Mental Hospital.[63] Premier Douglas launched a royal commission into the hospital's administration, chaired by the government's counsel, Morris Shumiatcher. MacNeill retired prior to the commission's work and Hazel Jacques resigned. Neither appeared at the hearings. The commission reported these findings and recommendations:

> Persons from kitchen employees to Deputy Ministers stated that Dr. MacNeill was a tyrant who ruled the hospital despotically, and according to his will and whim...even the Deputy Minister of Public Health admitted that he did not oppose him. That this doctor ruled with an iron hand, there can be no doubt. His influence was omnipresent. He regarded the hospital as his own private preserve. The principle that power corrupts was particularly apt in his case, for it caused him to regard the buildings as his own private estate, to treat the employees as his retainers, and to regard the patients as his subjects. The organization of the hospital was built upon the feudal principle of loyalty to one's master; and he succeeded surprisingly well in reproducing the characteristics of feudal serfdom.
>
> Separate and elaborate quarters were reserved for MacNeill, his matron Hazel Jacques, and his private secretary Lucy Gray. A special dining room was reserved for them and specially prepared dishes were served to them. On picnics, hunting trips and vacations to his cottage at Meota Lake,

> MacNeill took food, alcohol and supplies from the hospital. Hospital employees and patients were sent to Meota Lake to renovate the cottage, plant gardens and perform chores for Jacques and MacNeill.
>
> A marked contrast was found in administration on the male side of the hospital, as compared with the female side. On the latter, supervision appeared, if not adequate, far superior to that on the male side. It is apparent that female nurse-attendants receive training from qualified RNs. Supervision and training has been completely ignored on the male side. This has resulted in slovenly care and inadequate knowledge. No record of any type is maintained of drugs and there has developed a belief that staff members may use all the drugs which they require for themselves, their families and friends. This practise has resulted in the loss of thousands of dollars.
>
> There is scarcely a phase of the administration in which patients do not participate, and the tendency to exploit patients is very real. For example, in the power house patients are required to clean the furnaces, shovel out hot ashes and carry ashes outside. This is arduous work yet patients are engaged in this for longer hours than is required of paid employees. Complaints were received from aged men, of sixty-five years who stated that they were forced to shovel snow in the cold.
>
> It is the opinion of your commissioners that there is not a serious staff shortage but rather an under-training of attendants and nurse-attendants. Academic standing and the number of RNs are important factors to consider. It is recommended that training be made more intensive and compulsory. RN affiliation courses should be arranged for female attendants.[64]

While the royal commission examined only the mental hospital situation at North Battleford, the findings of this report provided an explanation for the lack of mental hospital training and nursing at both Saskatchewan hospitals. As Commissioner of Mental Services, MacNeill controlled the nursing situation at both institutions and prevented registered nurses from having an influence. For thirty years he staffed the two hospitals with poorly trained attendants. It probably would have been more difficult to exert such extreme control over registered nurses. Compared to Ontario, the Saskatchewan government's health department had played no role in the training and

staffing of its mental hospitals. As in Manitoba, it conferred the diploma in mental nursing, misrepresenting what the Saskatchewan training was about. Although this report was written after the war it answered some questions but raised others around Ellis' three-day visit with MacNeill at the North Battleford hospital in 1938.[65] She had come away from that meeting quite impressed and did not raise any red flags. Did she not observe MacNeill's outrageous behaviour or did she accept his authority because he was a physician?

Health care was one of the main issues in Saskatchewan during the 1944 election campaign and Douglas and the CCF party promised a socialized system of health care whereby every citizen would receive care without charge. Once elected, the Douglas Government set out to reform the total health care system, including its mental hospitals. The new premier wanted to direct health reform and took on the public health portfolio. He created a large bureaucracy and hired like-minded individuals to ensure that the reforms were rapid.[66]

Douglas commissioned two studies of the province's health care system, both intended to inform government around the proposed system of socialized health care. The first was a survey directed by Dr. Henry Sigerist, a medical historian from Johns Hopkins University. The Health Services Survey Commission (HSSC), or as it was better known, the Sigerist Commission, examined the health care system including both mental hospitals.[67] Sigerist pointed out the serious overcrowding at these latter institutions and the lack of trained staff, in particular registered nurses. The commission recommended that training had to be put in place prior to any changes in the mental health care system and that the government should finance mental health services for all patients.[68]

Accordingly the *Mental Hygiene Act* was amended to provide free mental hospital treatment.[69] Sigerist also advised that practical nurses and nurses' aides could assist with the nursing shortage throughout Saskatchewan, as long as such groups were registered.[70]

The second study focused exclusively on the mental health system, and once again, Dr. Hincks of the CNCMH was invited to carry out the survey. Hincks had always written in glowing terms of Dr. MacNeill's work in Saskatchewan and had even put MacNeill's name forward to the University of Saskatchewan for an honorary degree.[71] The province's royal commission on the Battleford Mental Hospital's administration was still forthcoming when Hincks noted these items:

> The Mental Hygiene Commissioner who has recently retired devoted [himself] wholeheartedly to the care and treatment of patients. He made great advances in abolishing physical restraints, barred windows and objectionable airing courts, and in strengthening occupational therapy, shock therapy, neurosurgery, hydrotherapy and in creating a hospital atmosphere.[72]

Some historians have argued that the CNCMH was used as a tool to professionalize the discipline of medical psychiatry, a charge which seemed evident here.[73] From 1920 to 1945 Hincks perpetuated the myth that the Battleford Mental Hospital was one of Canada's leading mental hospitals.[74] Other parts of his report were more realistic and similar to Sigerist's:

C1.	The greatest handicap is the degree of overcrowding at both institutions.
C2.	Reduction in the calibre and efficiency of attendant staffs due to war conditions.
C18.	It should be noted that although the ratio of attendants to patients is adequate, this cannot be considered satisfactory when one takes into account their academic qualifications.
C19.	The training school has no qualified nursing instructors.
D6.	Provide recognized training schools for student nurses with general hospital affiliations. Make possible the RN certification.[75]

Premier Douglas also consulted with Dr. George Stevenson, Medical Superintendent at the Ontario Hospital, London about the Saskatchewan mental hospital situation. Stevenson pointed out:

> Care for elderly persons at Canadian mental hospitals is an urgent problem. They add greatly to the overcrowding and require a high proportion of nursing care....It is desirable that nursing staff in mental hospitals be adequately trained in both physical and mental aspects and they should employ an adequate number of graduate registered nurses. If a training school for nurses is operated it should preferably train its students for the full nursing care of the patient, physical and mental. This cannot be done completely in a mental hospital and affiliations should be arranged in general hospitals.[76]

Sigerist, Hincks and Stevenson were consistent in their recommendations that the Saskatchewan mental hospitals required registered nurses, nurse training schools and general hospital affiliations for students. This, of course, was the model used for training mental hospital nurses in Ontario and the United States and the one that these men knew best. The Premier wasted no time with this feedback and began negotiating with Kathleen Ellis of the SRNA throughout the autumn of 1944. He clearly wished to get a plan in place.[77] Ellis made a point of informing Douglas that the SRNA attempted to initiate a reciprocal affiliation plan with MacNeill in 1938 but the length of affiliations for general students had become an issue.[78] While somewhat cautious with Douglas, Ellis was particularly enthusiastic about the potential for general students to affiliate at the two mental hospitals. Her enthusiasm centered on the educational need more so than the mental hospital needs. Douglas was advised that the SRNA council would review and revise the principles for affiliation, which had been developed six years prior.[79]

The Premier was in a hurry for the SRNA recommendations. He created some angst for some Council members and Ellis,[80] and there were numerous letters exchanged on the "question of affiliation". President Matilda Diederichs commented:

> I agree with you that the question of affiliation with mental hospitals will take much study and a lot of adjustment....Some things about nursing in mental hospitals will need to be modified or changed if our students are to go there....I do not agree that general students have to begin at the bottom by caring for untidy patients since they have learned that before affiliating. There is also the matter of seniority which is recognized in these institutions rather than ability. I still think that one year of affiliation for mental nurses to general hospitals is not enough. Could we not compromise between one and two years if the latter seems too long? If we must accept the former there surely will need to be extensive adjustments made in the mental hospital teaching program. Otherwise they will never be able to pass our registration examinations....I wonder if it is the lack of teaching the theory of techniques? I feel there is likely to be some feeling between general nurses and mental nurses regarding these and other matters....I am glad you are in Saskatchewan again since we can rely on your good judgement in handling these matters. I will be anxious to know what the Premier has in mind.[81]

It was apparent that besides the length of affiliations, differences between mental and general hospital environments were also a concern for the SRNA. Ellis and the Council obtained information about the new four-year combined mental and general nursing course offered by the Brandon Hospital for Mental Diseases and the Winnipeg General Hospital, which reinforced their belief that mental hospital students needed a two-year general affiliation.[82] Premier Douglas was sent the same four principles of affiliation which the SRNA developed when negotiating with MacNeill prior to the war.[83] Before forwarding this document to Douglas, Ellis conferred with legal counsel for the SRNA because "we realize this development is one which may have far-reaching implications".[84] The Premier was advised that further discussion and study would be needed prior to any decision on reciprocal affiliations.[85]

Douglas requested Dr. Mindel Sheps, Secretary of the province's new Health Services Planning Commission (HSPC), to negotiate with Ellis so that affiliations could be planned. In particular, Sheps wanted mental hospital students affiliating to general hospitals so that the standards of nursing care could be elevated. Ellis' desire for reciprocal affiliations for general students was not the government's priority.[86]

It is not known what Ellis meant regarding the SRNA's concern that an affiliation program for mental hospital students had "implications". However, the association was dealing with numerous changes instituted by the new CCF Government in its effort to implement a comprehensive health care program. It could have been that the association's leadership was unsure about its dealings with the new government.

One shortcoming of Saskatchewan's health care system was the lack of professional staff which resulted in an inequitable distribution of health care services. The new government wished to alleviate the shortages by attracting new professionals and by supporting new or previously unaccepted professions, for example midwives and World War II refugee health care workers.[87] Although the SRNA supported the education of nurse-midwives,[88] the Saskatchewan College of Physicians and Surgeons did not.[89] This lack of physician support, along with the government's perception that many refugee health care professionals, including nurses, were having difficulty obtaining recognition of their credentials did not sit well with the Premier and his Government. The Government's law amendments committee examined the powers of all professional groups and recommended that the licensing powers of such groups be removed.[90] Protest was widespread and included that of the SRNA:

> We are concerned over the drastic changes proposed and also somewhat surprised as it was our understanding that our association would have an

> opportunity to make further representation to the Committee. The changes would have unfavourable repercussions...and would compromise the standing we have with the Canadian Nurses Association.[91]

Similar opposition among all the province's professional associations caused the government to pull back. Licensing powers were left intact, but reports had to be filed whenever any individual was refused a license in a professional association.[92] And perhaps just as concerning to the SRNA was the government's refusal to include an amendment put forward by the association for inclusion in the new Health Services Act (Bill 49). One of Sigerist's recommendations involved the potential use of nurses' aides and practical nurses; and in a proactive move, the SRNA wished to define "nurse" as a nurse registered under the Registered Nurses Act.[93] Mindel Sheps advised the Premier against allowing this amendment:

> It will make it impossible to ever employ the services of practical nurses or nurses aides. We do not feel it would be wise to limit ourselves to the employment of registered nurses because there are many situations where other types of personnel can be used as efficiently. It must be kept in mind that there is an acute shortage of registered nurses and this will continue.[94]

The Premier's explanation to Ellis was less ominous:

> While government is desirous of having Saskatchewan's registered nurses used to the fullest possible extent shortage of same may make necessary use of hospital aides or practical nurses during this transition period. Do not feel can tie hands of all public bodies involved in this Act until the supply of registered nurses somewhat improved.[95]

Perhaps it was the Premier's paternalistic reassurance and a deference to government authority that prompted Ellis to thank Douglas for his explanation.[96] The College of Physicians and Surgeons meanwhile, refused to negotiate with Mindel Sheps and the HSPC, citing too much government interference in health care planning. Sheps was

forced to resign and government negotiations with the SRNA around the mental hospital nursing situation were temporarily suspended.[97]

It was Best for Saskatchewan

To this point there had only been minimal movement in the area of mental health care reform; and Premier Douglas spent much of 1946 finding a replacement for Sheps and recruiting a new commissioner of mental services. He convinced psychiatrist Dr. Donald Griffith McKerracher to leave the Ontario mental hospital system and direct reforms for Saskatchewan. McKerracher was born and raised in Ontario and graduated from the University of Toronto in 1935. He was among the early students who studied psychiatry under Dr. Farrar at the Toronto Psychiatric Hospital and the Ontario Hospitals at Whitby and London. He remained with the Ontario mental hospital service upon completion of his studies and before joining the armed forces practised at the Queen Street facility. He spent one year overseas and when Douglas recruited him he was on staff at the Toronto Psychiatric Hospital. He married a graduate of an Ontario mental hospital training school.[98]

As was often the case in psychiatry when provincial governments were unsure of what to do, McKerracher was given a lot of freedom and control of the mental health system. As commissioner, he was also the chief provincial psychiatrist and medical director of the Munroe Wing, the province's only psychopathic unit. He established a well-staffed psychiatric services branch of the public health department, which soon had the largest budget in the department. Under his direction mentally retarded individuals were separated from mentally ill individuals at the two mental hospitals and moved to a

temporary facility in Weyburn. The names of the hospitals were changed to match the Ontario system–Saskatchewan Hospital, North Battleford and so forth. He needed psychiatrists and recruited several from the United Kingdom and Eastern Europe.[99] Within a few months of his arrival he was perceived by the deputy minister of public health as Saskatchewan's savior:

> Mr. Premier: We are deriving dividends from having brought McKerracher to this province. Saskatchewan is on the way to a new day for mental health.[100]

And after a brief visit to the province, the well-known American psychiatrist Dr. Karl Menninger wrote:

> Dr. Griff McKerracher is a remarkable doctor. He has high ideals and is extremely skilled in administration. He saw what he wanted and got the funds and government grants. His provincial hospitals are remarkably well-staffed with their aides well-paid.[101]

Although he was not the tyrant that his predecessor MacNeill had been, McKerracher was a socially skilled authoritarian who was able to control the system and use people to his advantage.

McKerracher was faced with 4,500 patients in three institutions, the highest rate of institutionalization of psychiatric patients among all provinces; ten registered nurses spread between the three hospitals; and a staff of 500 unionized attendants and nurse-attendants trained only to provide basic custodial care.[102] His dilemma was "how best can mental hospital nurses be trained?"[103] It had then been two years since Premier Douglas first approached the SRNA for assistance in getting general hospital affiliations established for mental hospital students, and McKerracher quickly sought input from the association.[104] He requested an eighteen-month general hospital affiliation rather than the

two years as originally recommended to Premier Douglas.[105] It was evident that Ellis was in a quandary:

> It seems a reasonable suggestion. Confidentially I feel that decisions regarding requests similar to this may have some influence on the final decision reached regarding control of our Professional Act, although I realize that the Council would not wish to take any action which would compromise standards in any way.[106]

One member of the Council was more cautious than Ellis:

> This is to be encouraged. However, have we any idea what subjects are covered by these students he hopes to finish as registered nurses?[107]

Upon reviewing the mental training course outline, Ellis advised McKerracher:

> The course taken is considerably below even the minimum required in order that a nurse be eligible for registration in this and other provinces.[108]

McKerracher accepted Ellis' assessment of the status of the mental hospital training program:

> We are not too optimistic about being able to arrange for these employees to take their RN. We would encounter difficulty in sending the staff away for a period of time. There seems to be so many complications.[109]

Searching for the best way to train mental hospital nurses McKerracher traveled outside of Saskatchewan:

> I had the opportunity to talk to medical superintendents in California and Colorado and discussed it with Dr. Pincock in Manitoba and Dr. McLean of Alberta. Finally on a recent trip East I talked to Dr. C. Montgomery, Director of Mental Hospitals for Ontario, with several superintendents at the APA convention in New York and with Mrs. Laura Fitzsimmons, formerly Nursing Advisor to the APA. Also with Miss Ogilvie at the Department of Health and Welfare in Ottawa. With the exception of Miss Ogilvie the consensus was practically unanimous against training nurses in mental hospitals as the first step towards general registration. Ontario and Manitoba were considering discontinuing it and McLean said it made little or no contribution to the problem of caring for the mentally ill in Alberta. Mrs. Fitzsimmons says it is falling in disrepute in the United States. The reasons for the failure of what once seemed like a noble experiment are a) the students are not equipped for general hospital nursing, b) once they

> graduate from the mental hospital they do not return to the mental hospital and those hospitals are no further ahead for the time spent training these women, c) less resources available for general hospital students to affiliate to mental hospitals. We have concluded that for Saskatchewan it is not feasible to organize a mental nurse training program leading to affiliations with general hospitals and registration. This is a complete reversal from the opinion which I originally held when I arrived, although the difficulty of arranging general affiliations was becoming apparent last winter. With respect to the general student nurses affiliating to our mental hospitals for three months, we would be pleased to provide this but residence accommodation is a problem but...in future.[110]

Post-World War II, the nursing profession, especially in the United States, was adamant that specialty nursing education should not occur at the diploma level; so, considering the Saskatchewan training conditions, Laura Fitzsimmons likely did advise McKerracher against such a plan.[111] McKerracher considered training schools a failure if the students were not "staff" but it was unlikely that Ontario's Dr. Montgomery told McKerracher that his province's training was a failure. What McKerracher omitted to point out to Ellis was that except for Elsie Ogilvie, these individuals were not apprised of what the alternative to mental nurse training with general affiliations might be for Saskatchewan. In fact, McKerracher did not level with Ellis that upon receiving this "advice" he and some colleagues in Saskatchewan's public health department quickly revised the former attendant training program curriculum.[112] A presentation by McKerracher to the American Psychiatric Association offers more insight into McKerracher's decision-making:

> The three training programs considered were the combined mental and general nursing course leading to the RN; general students affiliating for three months; the British plan of training mental nurses. Almost without exception medical superintendents said "keep what you have got now, we wish that we still trained our own nurses, for not since then have we had adequate staff". Registered nurses were not readily available to act as teachers and administrators at our hospitals. The SRNA was not going to lower its standards. Why not reverse the procedure? Instead of depending

> on registered nurses, why not raise the standard of our hospital worker to a semi-professional status....It was decided to reorganize the staff training program, to increase the course hours and to make medical psychiatry rather than nursing care the major focus. Psychiatry accounted for over half of the 500 hours. The curriculum was developed by our medical superintendents and staff training supervisors. [113]

A report about McKerracher's presentation appeared in *The Canadian Nurse* under the headline "Is This the Answer?" The anonymous report was brief and the author was clearly surprised that McKerracher had chosen a three-year inservice training program modeled after the specialized British mental nurse training concept.[114] The author did not state her opinion, and the provocative headline did not awaken the interest of other Canadian nurses.[115] The Premier was unconcerned that the British plan was not consistent with the recommendations developed by Hincks and Stevenson.[116] Sigerist believed that Saskatchewan's registered nurses needed assistance from other groups, but the British plan adopted by the province excluded registered nurses.[117] McKerracher himself called it "Saskatchewan's unorthodox training program", but justified it on the grounds that "it was best for Saskatchewan at that time".[118] Ellis' reaction or lack thereof was a little puzzling. General hospital students in Saskatchewan were once again being denied mental hospital affiliations. In spite of being a nurse leader of the day, she deferred to McKerracher's medical authority and did not challenge his decision.[119] The anonymous writer at least raised it as an issue.[120] Perhaps Ellis realized that the reality of the mental hospital situation called for a more pragmatic solution. She remained hopeful that eventually reciprocal affiliations would become a reality.[121]

McKerracher's Unorthodox Training Program

The Saskatchewan Hospitals' Training Course for Psychiatric Aides was launched and endorsed vis-à-vis Premier Douglas' press release:

> ...today announced a new treatment program for more than 4000 patients in the two provincial hospitals. This change affecting both the staff and patients of the institutions...is intended to replace custodial care given by untrained or partially trained staffs....To make possible a more effective treatment program, nearly all employees of the hospitals will be required to take a three year training course which has been designed to qualify them as "psychiatric workers" instead of being attendants and nurse-attendants as in the past. This means that the hospital staffs will be given professional status and an active part in the treatment program. With the start of the staff-training program an effort will be made to attract young men and women with an educational standard of grade 11. Other qualities of personality, good health, general ability and insight will be considered. The Government hopes to find a sufficient number of young men and women of good character and idealism to enter this work as a career, not for a job. Employees will be required to take more responsibility and make definite contributions to improve the health of patients...every effort will be made to send people back to their homes. This task is a real challenge to all of us...looking for a career with good compensation and security.[122]

A well-organized recruitment campaign targeted grades eleven and twelve high school students during final examinations. Along with brochures, public service announcements and newspaper notices, church leaders were asked to help spread the news.[123] A government health educator who worked with Dr. McKerracher in recruiting almost two hundred high school students for the new program's first class attributed their success to the campaign: "We appealed to youth's idealism and desire to serve, and in the post-war confusion to youth's desire for security."[124]

Attendants and nurse-attendants at the two mental hospitals who had taken the former optional one hundred hour program and successfully passed examinations were not required to take the new training program. However, there were about two hundred attendants and nurse-attendants without the optional program and for whom the academic

requirement of grade eleven was an issue.[125] Many of the men had quit school at a young age during the Depression or to join the war effort. They were required to enroll in the new program.[126]

The psychiatric services branch of Saskatchewan's public health department assumed responsibility for the overall operation of the new program.[127] Some funding was obtained from the federal government's new mental health and health professional training grants.[128] There were no nursing instructors in the old program and a decision was made to engage three men as "supervisors of staff training". All had university degrees in education or psychology. They coordinated the training and were responsible to the medical superintendents at each institution.[129] Within a few years one nursing instructor for each facility was added, working under the direction of the staff training supervisor.[130] Hospital psychiatrists taught some courses.

The 500 hour three-year curriculum was divided into the following courses: medical psychiatry (250 hours), health sciences (100 hours) and practical nursing techniques (100 hours). There was minimal medical-surgical nursing content and the textbooks were medically focused.[131] Lectures were given outside the eight-hour work shifts, with first year students receiving two hours of class per day and second and third year students in class daily for an hour. There was no differentiation between male and female students. Clinical teaching was done on an informal basis by ward staff.[132] Dr. Sam Lawson, new Medical Superintendent at the Saskatchewan Hospital, North Battleford, designed the curriculum and had it ready for October, 1947.[133] Its purpose was:

> To develop in a well-selected attendant staff, the skills and knowledge which will fit them to provide psychological and physical care for mental patients.[134]

Except for minor revisions it was utilized through the next decade.[135] A key piece was the second year seminar course in which each student was assigned to a psychiatrist in order to learn assessment and history-taking skills. Even graduates of the former short program were required to take this seminar.[136] In order to graduate, students were required to attain fifty percent on each of four examinations: medical sciences, general and psychiatric nursing, psychiatry and medical surgical theory. An average of sixty percent overall was required.[137] Most of the examinations were developed and graded by psychiatrists.[138]

As in the former program, students were hired into attendant and nurse-attendant positions and retained that status throughout their three years.[139] New recruits most often started work on the wards during the summer months and worked during the summers after lectures ended in May.[140] About seventy-five percent of the apprenticeship program consisted of hospital service[141] for which students received a monthly salary of $100.00 for the first year, $155.00 for years two and three and $185.00 at graduation.[142]

Graduations at the North Battleford institution were a special occasion with Premier Douglas and his Deputy Health Minister Dr. C. Hames regularly attending. Both men had a vested interest in this new training program and enthusiastically supported it.[143] Most often the Premier thanked the graduates for "helping to build the mental well-being of the people of Saskatchewan".[144] Similar to the tradition at general hospital graduations, the superintendent of nurses led the students in reciting the Florence Nightingale pledge.[145] Once graduated, the staff were called graduate attendants and

nurse-attendants and remained on staff at the institution.[146] There was little mobility of staff between the three hospitals.[147]

There was no doubt that this new training component was the "jewel in the crown" of the government's program to reform mental hospital care in Saskatchewan. If the patient population at the three institutions were ever to decrease, a new approach to care was necessary.[148] By the end of the decade McKerracher reported that there were 863 trained graduates and students staffing the three hospitals, giving Saskatchewan the best staff/patient ratio in Canada.[149] He reported less staff turnover than during the war years and indicated that new recruits were meeting the minimum education requirement.[150] Perhaps because this "unorthodox program" was McKerracher's idea and so closely tied to the success or failure of the province's mental health reform program, he had a missionary-like need to sell and validate it to psychiatrists and others outside of Saskatchewan.[151] He presented papers, invited people to Saskatchewan to learn about it, submitted articles to medical journals and generally did everything possible to raise the profile of his new course.[152] The Premier was consistently kept informed of McKerracher's successes and his program took on a life of its own.[153] His greatest coup was the visit by the American Psychiatric Association's nursing consultant Lela Anderson in January, 1949.[154] McKerracher was serving on the APA's committee on psychiatric nursing at the time and created interest about his program among some committee members. That interest lasted only for the duration of his term, but during that time he was able to convince Anderson to evaluate the schools at North Battleford and Weyburn.[155] She reported:

> At the provincial hospital at North Battleford there are three registered nurses in addition to the superintendent and instructor of nursing. There

> were 125 graduates, 31 senior students, 55 intermediate and 101 junior students. The patient population here was 1859....Students are given the background and understanding so that they can take histories. We saw beautiful samples of histories taken by them. In the classrooms, on the wards and visits with individual students we were impressed with the quality of the students, with their interest and performance....Our experiences on the visit convinced us that this training program best meets the needs of all the patients and is satisfying to the worker himself....In hospitals where all students have high school or more, where the educational program makes provision for their development in making a professional contribution, where the students and graduates comprise the entire staff, where there are no untrained attendants, the outlook is indeed good for rehabilitation and recovery.[156]

Anderson was more than impressed with the fact that, compared to most of the American state hospitals which she evaluated for the APA, here was a province in Canada where virtually every staff person providing care was trained for that role. This report validated both McKerracher and his program and Premier Douglas was delighted with the APA's interest.[157] Even so, McKerracher embellished Anderson's report, advising others that his new program was considered "the best in North America".[158] His goal was for other jurisdictions to adopt it.

Not everyone was as generous in the assessment of McKerracher's new training program. Elsie Ogilvie, a registered nurse and consultant with the federal government's Health and Welfare's new Mental Health Division, attended a curriculum planning meeting with Saskatchewan psychiatrists. She had a disagreement with one psychiatrist who suggested that registered nurses should be responsible to trained male graduate supervisors, because she did not view the Saskatchewan training as equitable to general nurse training. Her report noted that Saskatchewan offered an in-hospital attendant training program and she did not believe it should be considered as anything more.[159] She expressed concern that there were no student libraries for the new program.[160] She

advocated for more registered nurses on staff and mental hospital affiliations for general nursing students in Saskatchewan.[161]

It was remarkable that these two nurse consultants had such differing opinions on the Saskatchewan mental hospital training program. Anderson's report considered the pragmatics of the immediate need for service by better trained staff, but it was too rosy. It could be that McKerracher influenced her thinking. On the other hand, Ogilvie's report was based on the ideal of educating general hospital student nurses for psychiatric hospital work vis-à-vis affiliations. Because RNs were almost invisible at Saskatchewan's mental hospitals in the late 1940's, this idea was not feasible.

Psychiatric Nurse or Nothing

The Premier's press release announced that the new "psychiatric workers would be given professional status"[162] but as far as the staff at the North Battleford Mental Hospital were concerned, they were still known as attendants and nurse-attendants and had little professional status.[163] They referred to themselves as graduate attendants and nurse-attendants.[164] McKerracher noted some difficulty in finding a suitable designation for the new "semi-professional" group[165] but because his training program was up and running, from his perspective, this was not an issue. But for some of the attendants, it was.

William Vowles, a British-trained mental nurse and President of the North Battleford Mental Hospital's CCL local three, approached Premier Douglas about the possibility of the attendants and nurse-attendants forming a professional association.[166] Douglas advised Vowles to work through Dr. McKerracher. However, McKerracher was

not interested in advocating the project because so few of the graduates from the original training program had any high school education. He refused to discuss it with Vowles.[167] Frustrated, Vowles sidestepped McKerracher and the UCSC hospital union took over.[168] He and union Secretary Lloyd Gardiner, who was not a nurse, wrote to Morris Schumiatcher, legal counsel for the Douglas Government:

> ...asking your advice on our attempt to organize a Psychiatric Association here at the provincial hospital. We propose to enroll all graduates in Mental Nursing and establish a separate association apart from Registered Nurses. The Union Executive is sponsoring this move and we desire to keep it free from control by the Medical Association. We feel that such control though indirect, is the biggest drawback to Registered Nurses. We believe that Psychiatric Nursing is now on the threshold of being universily (sic) recognized as the great new science and that unless they themselves organize they may well realize that the Canadian Medical Association has already taken the step for them. Do you think we can accomplish this without the Canadian Medical Association's blessing?[169]

Vowles, Gardiner and other hospital workers had worked for years under Dr. MacNeill's rule at North Battleford, and his replacement refused to endorse a professional association because of weak academic qualifications. However, McKerracher's goal was to improve the quality of training, not to create a profession. Vowles had also experienced medical psychiatry's monopoly of mental nursing education in Britain, reinforcing his desire for a professional association which would be free from such control.[170] The tiny group of union members who wished to become founding members of this professional association were graduates of the former one hundred hour course which had been offered from 1930-1947. Most of the men had grade eight education, and although they were not required to take McKerracher's new 500 hour course there was some apprehension that they were losing status to the younger and better educated recruits.[171] Considering McKerracher patterned his course on the British "mental

nursing" model, it is intriguing that the newer American designation "psychiatric nursing" was chosen by the union.[172] But as Vowles asserted "the goal was for it to be psychiatric nurse or nothing".[173]

Shumiatcher advised the two men to incorporate psychiatric nurses, with similar duties and powers as contained in Saskatchewan's Registered Nurses' Act. [174] He pointed out the legitimate case they could make. That Act applied only to women and dealt with training in basic nursing, infants, obstetrics and tuberculosis.[175] Vowles attempted to draft an Act which would incorporate a "registered psychiatric nurses association" but instead it read as though it was for a fraternal association.[176] Dr. Shumiatcher wrote:

> I believe your draft requires considerable redrafting. I shall be pleased to do this on your behalf. In the meantime I suggest you organize a society and enroll as many members as possible. You will not have a statutory basis for your organization but will have a membership which will in all likelihood impress the Legislature with the importance of enacting the proposed Bill. I would set the dues reasonably low.[177]

It was then up to Vowles to create some interest among his colleagues in forming a psychiatric nurses' association. He did not bother with the newly recruited students but rather lobbied the graduates of the original program; in January, 1948 he and other members were elected to the executive.[178] Vowles noted that the UCSC hospital union assisted with the ongoing organization.[179] He was unable to get the graduate attendant staff at the Weyburn Mental Hospital interested in joining the new association; but finally two union colleagues did so, giving it the necessary provincial status.[180]

Shumiatcher created the Act for the new association from his copy of the SRNA Act, but disappointed Vowles because he did not use the term "registered" in reference to the new association and its members.[181] Vowles' colleague, on the other hand, believed the omission was deliberate so that there would be less opposition to the Bill's passage.

Shumiatcher did not share his reason even when pressed.[182] The missing word did not stop the union executive from asking Premier Douglas for his assistance with the next step. Douglas, who was receptive wrote:

> Dear Lloyd:
> Thank-you very much for the draft bill to incorporate a Psychiatric Nurses Association....In all probability it will have to be brought in as a private member's bill. I am quite sure that Alex Connon would be willing to introduce it....[Have] you notified when this organization would have to appear before the Law Amendments Committee of the Legislature.[183]

The Premier was unaware that Shumiatcher had written the Bill for the new association and asked him to review it and contact Connon, CCF member of the legislature (MLA) for the Battlefords to sponsor it.[184] Although this was to be a private member's Bill, the fledgling association received some solid assistance from government. Three weeks later Shumiatcher contacted Dr. McKerracher:

> ...two copies of the Psychiatric Nurses Bill...proposed to introduce during the current session. Kindly peruse and provide us with any suggestions. We should like the Bill to go to the printers tomorrow the 14th.[185]

This was McKerracher's first knowledge about the proposed Bill, but there may have been reasons for not allowing him any time for feedback. The hospital union and McKerracher disagreed on McKerracher's authority around a number of issues and the union executive had taken their concerns about McKerracher to Mr. Connon, their MLA. Without fail Connon reported the union's complaints to the Premier. In autumn, 1947 he wrote:

> Dear Tommy,
> Dr. McKerracher is responsible for the disturbing situation at the hospital between employees and administration. McKerracher told them there was too much politics at the hospital and warned union officials that their jobs would be insecure if there was a change of government. He told them they should not talk to their MLA about hospital matters.[186]

Douglas advised Connon that he would "talk to him".[187] Besides control issues, there was a perception among union members that McKerracher was not comfortable with the relationship between their union and the CCF Government. At times the union executive wrote directly to Douglas about McKerracher's behaviour:

> Why was it necessary to go to Conservative Ontario to bring in a man who is blind to everything else but higher academic qualifications and make him the Commissioner? We don't need McKerracher remodeling Saskatchewan's hospitals. Many men without grade 11 are being fired...they had to leave school during the hungry thirties...a ruthless policy. We support our CCF Government and this great movement for which we have worked. Certain professional men...over-zealous....[188]

McKerracher, caught off-guard by the proposed Bill, and knowing that the Premier would not be receptive to his concerns later contacted Ellis, who was. This was, after all, no longer just about an expanded mental hospital staff training program announced in a government press release, but rather about the creation of a new nursing profession in Saskatchewan.

Psychiatric Nurse It Was

Although McKerracher was notified on February 13, 1948 about the proposed Act he waited until March 3 to advise Ellis.[189] They discussed McKerracher's views on the matter and he put them in writing for the SRNA:

> Concerning the proposed legislation with respect to the formation of the Psychiatric Nurses Association: I would agree with the general principle that qualified trained ward personnel should be entitled to form an association in order to maintain professional standards. However I am in disagreement with the choice of title for this association. I consider the use of the term "psychiatric nurse" as an unfortunate selection. In the first place the training programme is fitting the ward staff for a therapeutic rather than nursing function. I do not believe the term "nursing" describes either the training which this group receives or the responsibility which it will be given. An added reason for my disagreement with the title

> "Psychiatric Nurse" is the fact that such a term is bound to create confusion with respect to distinguishing the members of this group from Registered Nurses with psychiatric training. I discussed this matter with Mrs. Laura Fitzsimmons, former Chief Nursing Consultant with the American Psychiatric Association who is the best informed person on the continent with respect to the problem of mental hospital staff training. She states that "psychiatric nurse" is an unsatisfactory term to use to describe the mental hospital trained staff.[190]

McKerracher did not advise Ellis that the sensitive "psychiatric nurse" designation threw a wrench into his goal to have jurisdictions outside the province adopt his training program. Two days later Ellis, McKerracher and Ethel James, President of the SRNA, met with Dr. Hames, Deputy Minister of Public Health, who was opposed to the formation of the professional association but did not mind if the term "nurse" was used by the hospital workers. He told the delegation that he was "renouncing any responsibility in this matter".[191] As Premier Douglas' deputy minister, Dr. Hames most likely had been informed that the proposed Bill was in process. He was a civil servant who was not interested in the special relationship between the hospital union and the government. Like McKerracher, he had already had disagreements with union officials concerning educational qualifications of untrained attendants.[192] And as Ellis was then painfully aware, the use of the term "nurse" was generic under the government's new Health Services Act.[193]

Frustrated and getting nowhere with these two physicians, Ellis called Premier Douglas. Apparently the SRNA had not been informed of the Bill's existence because it was a private member's Bill and not originating from Government, or at least that is what the Premier told Ellis.[194] He did not advise her that he had helped guide the Bill through the required steps and had even suggested who would sponsor the Bill. They agreed to

meet the next morning (Saturday). Meanwhile an emergency meeting of the SRNA council was held, at which time a motion was passed:

> The use of the term "psychiatric nurse" was misleading to the public, to persons taking the course and to the nursing profession. If necessary, representation to this effect should be made to the Law Amendments Committee. All steps possible will be taken on behalf of the SRNA to have the use of this term reconsidered.[195]

Just a few years earlier Premier Douglas had asked the SRNA for help in getting affiliations arranged so that the mental hospital workers could take general nursing and become registered nurses.[196] Why did he then seem insensitive to the concerns of the SRNA and why did he want this Bill passed? Besides the special relationship which the CCF Government had with the labour union at the North Battleford Mental Hospital, there were other factors. The government was determined to reform health care in Saskatchewan quickly and though it tried to work with the established health professional groups, they tended to respond slowly or to block reforms.[197] Douglas might have perceived this to have been the case around his call for help with the general hospital affiliations. The SRNA studied his request but, concerned that such affiliations were not "educationally sound", did not act.[198] There was a belief among some in government that the professions ran a "closed shop" and were elitist in nature; so Douglas' championing this new profession for marginalized hospital workers was one method of preventing a monopoly by registered nurses.[199]

Ellis was anxious because the Premier only stayed for a short period at their Saturday meeting. Instead she had to lobby in writing:

> We feel that this association is justified in asking for reconsideration of the use of the term "psychiatric nurse" in the Bill. We are not opposed to the recognition, through legislation, of those who would be affected by the Act. We have the greatest respect for those who have carried the major

> portion of the work in the Saskatchewan Hospitals over the years and it is in the interests of possible future developments, as well as present repercussions, that we are making these points to you:
>
> 1. The term "psychiatric nurse" is generally accepted, in both Canada and the United States, as interpreted to mean a registered nurse who has had a special course and experience in psychiatric nursing. Regardless of what may be set forth in the Act, we are sure that you will agree that the interpretation of any term involving the word "Nurse" will devolve upon this association. The Commissioner of Mental Services expressed himself that the use of the term "psychiatric nurse" as suggested in the Bill is a misnomer. We endorse this opinion.
> 2. For many years this association has been interested in reciprocal affiliations. Correspondence on file in this office, initiated by this association, goes back to 1938. Approaches regarding the question of affiliation have been made at intervals since, the last in early 1948. Although Dr. McKerracher does not see the way clear to establishing such affiliations at the present time, he is definitely interested. We realize that such affiliations may not be practical at the present, but refer to it as evidence of this association's interest in the mental hospitals.
> 3. It would seem that Bill 69 was prepared rather hurriedly, at least we are given to understand that the Commissioner of Mental Services was only advised of its existence within the last two weeks. He felt this association would be affected by the proposed legislation. We urge therefore, that action be deferred until such time as more study can be given to such an important step, one which will undoubtedly affect mental hospital developments in this province.[200]

In communication with Ethel James about item two, Ellis explained that she purposely omitted suggesting to Douglas that general hospital students could help with the mental hospital nursing shortage by affiliating. She wrote:

> Confidentially, I thought that this would not appeal to the mental hospital group but it might to the Law Amendments Committee if we have to appear before it.[201]

There was no response from the Premier about deferring the proposed Bill, which meant the SRNA had to appear if it wished to express opposition to the proposed name for the new profession. Ellis was successful in getting the chairman of the law amendments committee to delay the hearings, but only for a few days.[202] Mr. Connon, the Battlefords MLA, did not want to give the SRNA time to mount a strong opposition.[203]

Ellis had five days to prepare but did not consult with the association's legal counsel nor with any colleagues outside of Saskatchewan. McKerracher prepared notes for the Council and Ellis prepared a presentation guide for President James.[204] Curiously, Ellis chose to attend a CNA executive committee meeting in Winnipeg instead of appearing at the law amendments committee hearing on March 17.[205] For someone who had been so concerned about the consequences of this proposed Bill, it is puzzling that she did not remain in Saskatchewan for an extra day. It was unfortunate timing.[206] In her position as the CNA's emergency nursing advisor, she had given many presentations to government officials and likely would have been more forceful than her colleagues. She was known to be determined in nature and committed to projects she undertook.[207] However, her report later that year noted: "Changes and adjustments are taking place so rapidly that it is a challenge to keep pace with them."[208] Her advice for James and the two Council members delegated to appear before the committee was "to request delay if the term psychiatric nurse is to be used".[209]

Vowles recalled later that he would never forget his morning with the law amendments committee:

> I was chosen by the Association to explain the reasons for requiring our Association. I was there alone and there was a strong gathering of Registered Nurses, including their President and Registrar. There were 40 members of the Laws Committee and Alex Connon. The registered nurses made a strong case of opposition to the Bill. A guardian angel must have been with me…I was able to convince the Committee our title Psychiatric Nurse was distinct from Registered Nurse….There was not one vote against us. We were of equal status to Registered Nurses. The speedy acceptance of our Act was a great surprise to the Registered Nurses, the Deputy Minister and others in high places in psychiatry. No preparation had been made to set things up with the University for examinations and registration. We were fortunate the Committee accepted our application that day. Had it been hoisted for one year the RNs would have had the chance for legal representation.[210]

The three members of the SRNA executive presented a matter-of-fact report to Council. There was no second-guessing around Ellis' decision to miss the law amendments committee meeting or the lack of legal consultation.[211] Ellis and her colleagues never discovered that the Psychiatric Nurses' Act had been copied almost word-for-word from their Registered Nurses' Act by a government lawyer.[212] Although she thanked McKerracher for his help, Ellis was aware that the SRNA had been manipulated. She did not believe that he ever told the psychiatric nurses that he opposed their new designation.[213] Before it reached the House for a third reading, Deputy Minister Hames argued against the inclusion of clauses seven and eight in the Psychiatric Nurses' Act.[214] Clause seven "grandfathered" all graduate attendants and nurse-attendants who had trained in the former one hundred hour course to the register without examination.[215] These were the same people that the Premier and his Government believed were treated unfairly by the established professions and the ones who had initiated the association, so Hames got nowhere. Clause eight established a relationship between the new profession and the Senate of the University of Saskatchewan, similar to that between the SRNA and the university. The university was to prescribe a curriculum and set examinations. This relationship validated the professional status for this new profession because the UofS had legislated responsibility for all professional education.[216] It was part of the SRNA's Act and Shumiatcher simply replicated it in the new Act, even citing "branches of the profession".[217] He, of course, was unaware that the new profession did not have branches or specialties–it was in the view of most general nurses, a specialty. There were no changes and on March 25, 1948 Bill 69, The Psychiatric Nurses' Act, was passed by the Saskatchewan Legislative Assembly.[218] Three days later Vowles and local three of the

United Civil Servants of Canada thanked Dr. Shumiatcher for his help in "obtaining professional status".[219] It was a stunning victory.

Psychiatric Nursing Post-Legislation

In spite of the birth of the new Psychiatric Nurses' Association of Saskatchewan, work life for its nurses carried on. The North Battleford Mental Hospital union continued to act as the nurses' voice, even in issues around education. Both Connon and Vowles wrote to Premier Douglas complaining about McKerracher's support of Mr. F. MacKinnon, supervisor of education.[220] The students wrote letters of complaint about MacKinnon's course and the union executive was asked to resign to protest MacKinnon's tenure.[221] Douglas was told that both men were disliked, and upon reading the letters of complaint he advised McKerracher:

> I read these letters with a good deal of concern. While some of the complaints are rather picayune the whole tone of them makes me wonder as to whether Mr. MacKinnon can possibly make any useful contribution to the life of the institution at Battleford. It might be wise to move him. With a fresh start and with some of the lessons he has learned from these mistakes he has made, he may be able to use a better approach to those whom he is responsible for training.[222]

McKerracher liked MacKinnon's work and saw the complaints as a "mass venom".[223] The deputy minister suggested to Douglas that the hospital union was dictating to the government, but nonetheless Douglas and Connon terminated MacKinnon's employment.[224]

Vowles and the union were easily able to negotiate with the government for the new classification "registered psychiatric nurse", meaning a psychiatric nurse had successfully passed examinations and paid registration fees.[225] However, some graduates

from North Battleford were not clear about the term "registered" and applied for registered nurse positions. The SRNA was notified of the applicants and the new classification,[226] prompting a letter to McKerracher:

> Those taking the course might need definite advice. May we suggest that the term "registered" psychiatric nurse is causing some confusion. The Act specifies that those taking the course shall be known as psychiatric nurse. The term registered is not included.[227]

It is not clear whether or not McKerracher was aware of the new staff classification called "registered" psychiatric nurse. He was embarrassed that North Battleford graduates had applied to general hospitals and remained unhappy with the legislation:

> Their registration does not permit them to do general nursing. They are misunderstanding the significance of their qualifications....I would personally heartily second your objection to the term "registered" psychiatric nurse....As you know I have always objected to the term psychiatric nurse in its application to our staff training. We have tried to find a suitable title for this group of workers but have not found an acceptable one.[228]

There was no doubt that McKerracher was ambivalent about this new profession and especially its title. There were ambiguities around the group of psychiatric nurses who had trained in the old program, with the main problem being their low level of education and high level of union activism. However, as more young people with high school education entered the training program he began to object less to the use of their title psychiatric nurse.[229] There was evidence that he used this designation less whenever he published an article or spoke to a non-Saskatchewan audience.[230] The terminology issue remained a threat to his mission to promote acceptance of the training program outside the province.

It was doubtful that, having achieved an Act legislating their new professional association, Saskatchewan's psychiatric nurses would ever agree to a name change.

However, the psychiatric services branch of the public health department examined the issue, perhaps because there had been no time to do so prior to the passage of Bill 69 and likely under McKerracher's direction. A report done on the new staff training program noted some issues and problems:

1. There is no term which adequately describes this new type of trained ward staff. Terms in use include psychiatric aide (USA), psychiatric technician (USA) and psychiatric nurse (Saskatchewan).
2. It is agreed that the general nursing profession will never be able to supply the enormous demand for mental hospital nursing care. Registered nurses see the new ward staff as having inferior training.
3. Will the attendant role still exist with the new ward staff?[231]

Both the government and the new association were slow to inform the University of Saskatchewan that the Senate was responsible for approval of the psychiatric nurses' curriculum and examinations. Ironically, the U of S board of examiners and registrar relied on Ellis to help sort it out.[232] The whole process took so long that it gave Ellis one final chance to lobby Dr. Lindsay, chairman of the board of examiners, for inclusion in the curriculum of a general affiliation for the mental hospital students.[233] She informed the Senate that "a considerable sum of federal government health grant money was being spent on training this restricted worker", while the nursing profession believed in a generalist preparation.[234] The Senate approved the curriculum which Dr. Sam Lawson, Medical Superintendent at North Battleford designed.[235] Ellis' suggestion was not brought forward.[236]

The board of examiners created numerous problems for Dr. Lindsay and the Senate. It consisted of several psychiatrists and one superintendent of nurses, all selected by McKerracher. For several years the examination process was mangled. The nursing examination consistently resulted in candidates receiving low marks and failures, and the

superintendent of nurses accused the psychiatrists of inflating the grades on their examinations:

> ...wonder if the results are due to scaling their marks? I tried to make these examinations easy but I also have certain standards of achievement and if you feel my standards are too high then I would prefer to withdraw. Many students have not taken their training seriously enough and think this course is something apart from their job.[237]

Miss Copeman did not withdraw and students continued to fail her nursing examination. The new association complained to McKerracher who in turn asked the University of Saskatchewan to disband the whole board of examiners and replace it with appointees selected by the new association.[238] Dr. Lindsay was unhappy with McKerracher's interference in the university's mandate. He suggested to McKerracher that maybe it was something other than the nursing examination which was causing all the failures;[239] and in a letter to the university president, Lindsay stated his perception of the issue:

> This is not an established profession and things are so different than with our usual board of examiners. The attempt to impose adequate standards on the psychiatric nurses has caused this trouble. Miss Copeman maintains the students are insufficiently trained and therefore cannot pass a reasonable examination. She has taken a courageous stand in an attempt to correct what she thinks is wrong.[240]

The government created this new profession but was unable to confer the usual attributes of a profession, such as autonomy, self-regulation, distinct body of knowledge, and altruism.[241] Hence the association depended on the government, the hospital union and sometimes even psychiatrists to meet its needs. An early graduate suggested that psychiatric nurses "were protected by a pattern of paternalism".[242] For example, the association could not get enough psychiatric nurses at the Weyburn Mental Hospital to form a branch, hence the union collected professional fees for the association at this institution. Vowles noted that except for a few members at North Battleford, there was a

high level of professional apathy.[243] Further, the association was not given representation on government health committees as was the SRNA.[244]

With the passage of the Psychiatric Nurses' Act the concept of psychiatric nursing as described by the SRNA was forever changed in Saskatchewan. Psychiatric nursing was no longer a specialty of general nursing[245] but rather a separate and distinct occupation. Ellis had worked on "the question of affiliation" for over a decade, even conducting a final lobby after this Act became law. But perhaps it was McKerracher's emphatic response to her final lobby which allowed Ellis to realize the finality of the situation:

> An affiliation course such as at Ponoka in Alberta and Brandon in Manitoba will not be adopted in Saskatchewan. We are recruiting and training staff for a psychiatric function not the basic sciences which are for general training. This course does not offer an appropriate foundation for a general nursing affiliation. The students are informed that they are prepared for work only in Saskatchewan's mental hospitals. If they wish to become registered nurses they should do so after completing the mental hospital course.[246]

There remained "the question of affiliation" for general hospital student nurses needing a psychiatric nursing experience. Neither McKerracher nor the SRNA was committed to sending such students to the province's two mental hospitals, but there was a renewed effort to expand the small program at the Regina General Hospital's Munroe Wing. Ellis and the newly-appointed federal government's consultant in mental health nursing, Elsie Ogilvie, established a collegial relationship when Ogilvie was in the province assessing the new mental hospital curriculum, and they agreed on the importance of affiliations which were based on a "sound educational basis". They communicated about the pressing need for registered nurse leadership in the psychiatric nursing specialty in Saskatchewan.[247]

The eight-week affiliation course only became possible with a federal mental health grant to the Saskatchewan government's psychiatric services branch.[248] As was the case with the mental hospitals, the psychiatric services branch under McKerracher also controlled the Munroe Wing. Before long it became evident that there was an over-abundance of student service, but the SRNA was reluctant to intervene, fearing for the survival of the affiliation.[249] Aside from the mental hospitals this small 27 bed psychopathic unit was the only setting available for the care of psychiatric patients in the province; this meant that only one hundred Saskatchewan general hospital students received the affiliation each year. The remainder received two lectures.[250] The answer to the "question of affiliation" was difficult to comprehend. Over 4,000 patients at two mental hospitals could have easily provided learning experiences for all 900 general students, but factors unrelated to their care did not permit it.

Ellis did not mention the newly legislated occupational group in her reports to the CNA but it did not take long for the news to travel to Ontario. A professor of nursing at the University of Toronto School of Nursing had obtained an article from *The North Battleford Optimist* describing a visit by Dr. Aldyn Stokes to the North Battleford Mental Hospital. Stokes was a British educated professor of psychiatry, also at the University of Toronto, and had been contracted by the federal government to survey mental hospitals.[251] The newspaper article described McKerracher's new professional training program and Stokes' interest in same, prompting this letter to Ellis:

> One cannot always follow newspapers but the North Battleford Optimist makes some very definite statements with regard to Saskatchewan Registered Psychiatric Nurses which could be rather alarming. We are in need of information for we have heard various bits of conflicting opinions. Some of our doctors have been to Saskatchewan and we have heard they may be sympathetic toward a new program here for psychiatric nurses

> which would be different from our idea of registered nurses with psychiatric affiliations or the combined course as carried out in Ontario. It is urgent that we be kept informed in as much detail as possible.[252]

Perhaps Ellis was less aware of the potential significance of the new occupation than some Ontario nurses. Or perhaps she did not know that McKerracher was on a mission to sell his new program to psychiatrists outside of Saskatchewan. Nevertheless, this was much more than a training course. Registered nurses never achieved a presence in Saskatchewan's mental hospitals. Thus, she was not concerned that from 1948 when the legislation was passed, to 1950 when this communication took place, the number of registered nurses working in Saskatchewan's mental hospitals was stagnant at eight.[253] In Ontario registered nurses had a significant presence at the mental hospitals, and news of the new group was perceived by some as a potential threat to their professional status. In her description of the SRNA's response to the new development it was evident that Ellis had become accustomed to the politics in Saskatchewan:

> When the Act was passed this association definitely opposed the use of the term "psychiatric nurse" as it was inappropriate. On paper the course appears sound but its implementation may be another question depending on the teaching staff. The students are paid substantial salaries beginning at $110 per month with yearly raises. I think that as a profession our concept of a psychiatric nurse is one who has a very sound knowledge of the physical and mental aspects of the human being. Therefore we believe their title is a misnomer. We believe the course has improved the staff and the care of patients. However, one does question whether it is sound to require the trainee to spend a full three years in order to qualify for this specialty? And there is the question as to whether they will be recognized outside of Saskatchewan as anything more than trained attendants. You can get details about their course from Dr. McKerracher.[254]

The Ontario nurse refused to contact McKerracher and Ellis retired to British Columbia three months later.[255]

Memoirs of Some Retired Saskatchewan Registered Psychiatric Nurses

Without exception the retired Saskatchewan psychiatric nurses reported growing up in rural Saskatchewan in small towns or on farms–Rockhaven, Cutknife, Landis, Marlan, Laird, Lashburn, Baljennie. In some cases their parents had emigrated from Eastern European countries or from the United Kingdom and for others it was their grandparents who had done so. Anna Shynkaruk arrived in Saskatchewan from Poland as a young girl.[256] Two described their parents as being homesteaders.[257] Except for one, all categorized their families as working class and several had experienced extreme poverty during the Depression. Anna Shynkaruk said that her father moved her family at least once a year in search of work, and shelter often meant an empty granary. She struggled to learn how to speak English as she moved from school to school.[258] Other sources confirmed that almost all students listed rural Saskatchewan addresses as home, with few from the cities of Saskatoon or Regina.[259] Family names were evenly split between Anglo-Saxon and Eastern European backgrounds.[260]

There were two common and complementary threads as to what influenced the retired Saskatchewan psychiatric nurses to enter the training school at the mental hospital. Except for two, each had "dreamed" of becoming registered nurses as they were growing up. Some had played "nurse" with dolls and so forth. None was a daughter of general or mental nurses and none had sisters who were nurses. They were between 18 and 20 years old when they began training, and except for Anna Shynkaruk, all had completed grade twelve. Most of these women likely could have gone into general hospital training schools in Saskatchewan, but only one applied. They explained that their families could not afford general hospital tuition and uniforms or needed their daughters'

incomes. Dorothy Mulder (Campbell) recalled that she decided on North Battleford because she only had "to find money to cover the cost of new duty shoes and stockings".[261] Elsie Pernala (Maksymchuk) confided "I hate to say this but the money I'd be making at North Battleford made the difference for me".[262] Mabel Hubbs (Broley) was even more forthright, "going to the mental meant getting a salary, period".[263] Grace Kurtz (Murdoch) found employment at a local bank after a grade twelve for $30.00 a month, but when she heard through a girlfriend that she could become a nurse and make at least $100.00 a month, she applied.[264] On a more altruistic level, Selma Loewen (Epp) reported that her local Mennonite church encouraged both she and her brother to apply at North Battleford, related to the Saskatchewan government's recruitment campaign for high school students.[265] Two of the women helped support their widowed mothers during training.[266] It was notable that except for Selma Loewen's (Epp) family, the families were not initially enthusiastic about their daughters' choice to train at the mental hospital. Most of the families knew little about the hospital, but nevertheless did not see it as a respectable place for young women to train. A few thought it was unsafe. Dorothy Mulder's (Campbell) father warned her that the work was too hard for a woman and the North Battleford Mental Hospital environment was rough.[267]

Most of the retired Saskatchewan psychiatric nurses spent at least a few months working as nurse-attendants at the hospital before classes started in October. There was no orientation to the hospital and within the first hour they were sent to a ward to begin patient care. Without fail they felt overwhelmed and afraid with what they observed and experienced. Elsie Pernala (Maksymchuk) was told to get a full ward of female patients to breakfast and did not know how to begin.[268] Anna Shynkaruk said she "felt numb

when she walked onto a ward with hundreds of women".[269] Mabel Hubbs (Broley) recalled the wards being so crowded that she had to take off her shoes and climb up on the beds to make them.[270] Dorothy Mulder (Campbell) better understood why her parents had been apprehensive. This is how she recalled her first day:

> The first thing I saw was a lively beautiful coloured girl. She was about 5 feet 6 inches tall and about 100 pounds and she was covered with her menses. She had wiped menses all over her, head to foot. And I thought, now I know why Dad and Mom didn't want me to go here, but then I thought, no, they didn't imagine it would be this bad.[271]

The retired Saskatchewan nurses recalled enjoying the daily lectures but that classes were just a small part of their workday. Most of the lectures were given by psychiatrists or by physicians who came from North Battleford. The superintendent of nurses gave general nursing lectures, but psychiatric nursing was never taught in the classroom.[272] Dorothy Mulder (Campbell) used the care of suicidal patients as an example, explaining that the theory did not get taught; but when she had a suicidal patient to care for, a staff nurse then told her "what to do".[273] They did not use textbooks and for spring examinations had only their lecture notes to study.[274] Selma Loewen (Epp) and Grace Kurtz (Murdoch) noted that sitting in lectures reminded them that they were student nurses, because that did not seem to be the case when they were working forty-four hour weeks on the wards.[275]

For the most part the retired Saskatchewan nurses described psychiatric nurse training in the mid and late 1940's as custodial care–bathing, feeding, toileting and exercise. And unlike general hospital training, the nurses did not learn these basic skills in a classroom or laboratory. Mary Gerbanski and Anna Shynkaruk recalled giving bed baths without ever being shown how–"you just did it".[276] More complex clinical skills

were taught to students by staff nurses or senior students. There was no nursing instructor assigned to the wards to help students learn clinical skills.[277] Grace Kurtz (Murdoch) said that she was shown how to do an intramuscular injection in one ten minute session by a staff nurse giving an injection, then the next time she did it on her own.[278] Anna Shynkaruk thought that out of ignorance she "probably did some things that I should not have done".[279]

The nurses were also taught hydrotherapy techniques, insulin shock treatment and the newer electroconvulsive (shock) treatment. Dorothy Mulder (Campbell) pointed out that these treatments took a lot of nursing time but relatively few patients actually received these treatments.[280] All of them remarked on the nursing care which they provided to patients receiving shock treatment. They said it was often unpleasant because many patients initially resisted having the treatment.[281] Selma Loewen (Epp) and Mary Gerbanski explained that it took at least four nurses to "hold a patient down" during the grand mal seizure.[282]

When these nurses trained, psychiatric nursing did not involve much talking to patients on an individual basis about their personal problems. There was not such a thing as "communication skills" or "therapeutic communication"; but rather the nurses remarked that a huge part of what they did was constantly observing patients in large groups.[283] Selma Loewen (Epp) said she needed "eyes in the back of her head" most days. But she also believed that she gave individualized care because she "treated every patient as though it was her own mother".[284] Anna Shynkaruk thought that her own difficult life helped her to better understand her patients. She explained that she was "non-judgmental without ever being taught how".[285]

The retired nurses fondly recalled the community atmosphere at the hospital but a few of them pointed out that the hospital hierarchy was problematic. Anna Shynkaruk said they were taught that standing for physicians was a "show of respect" but she resented having to do it.[286] Others said it quickly became a habit and they never questioned it,[287] with Dorothy Mulder (Campbell) noting it took her several years after graduation before she "stopped standing for doctors".[288] None was in training during MacNeill's tenure. There was also a defined hierarchy between the students in each year of the program. First year students went last through a door and were assigned the least desired ward work.[289] Selma Loewen (Epp) recalled how she quickly learned that "when you were in first year you cleaned everyone's teeth".[290]

The hospital was divided into male and female sides or services and the retired nurses noted that there was never a reason for them to ever go to the male side since the male students and nurses were trained for patient care. They all said there was no reason given for the separation and that it was simply hospital tradition.[291] The male side had a chief male nurse who was equal in status to the superintendent of nurses. Except for meals and hospital social events the nurses only saw their male colleagues in class. These nurses thought of themselves as equal to the male students.[292]

In contrast to general hospital training schools, life at the North Battleford Mental Hospital was not one full of rituals and traditions around residence and uniforms. There was a comfortable nurses' home and while Dorothy Mulder (Campbell) was delighted with her own room, the rest of these students chose to "live out" of residence with either family or friends. They were considered hospital employees and there was no rule about living at the hospital. None complained about the added cost of living in town

and none believed that she missed anything in her training because she was not in residence.[293] Grace Kurtz (Murdoch) said "we worked hard and we played hard".[294] Several noted that they made lifelong friendships with some classmates.[295]

Their blue and white striped dress uniform with its starched white apron, bib and collar remained the same from one year to the next. There were no crests or pins or stripes which identified the seniority of a student. There was not a probationary period and caps were issued at variable times–at admission, after three or six months and so forth. There was not a formal "capping" ceremony as was common at general hospital schools.[296]

The retired nurses believed that they had been well-trained to work at the mental hospital. All felt they had made the right decision and in fact said they would do the same thing over. Mary Gerbanski and Anna Shynkaruk explained that for them it had been a job and their training was a bonus.[297] All except one had remained in psychiatric nursing in Saskatchewan until retirement.[298] Two of the nurses had been active in the Saskatchewan Psychiatric Nurses Association following graduation.[299] None became involved in union activities. There was no hospital alumni association. Half of the nurses recalled incidents during their careers when they perceived that registered nurses had not recognized them as professional equals.[300] Selma Loewen (Epp) said her biggest disappointment was when she left North Battleford following graduation and had her new credentials challenged by hospitals in Manitoba because officials were unaware of Saskatchewan's training program. She could not become registered or practise psychiatric nursing because it was not recognized.[301]

Summary of the Saskatchewan Case

The emergence of the new occupation of psychiatric nursing in Saskatchewan signaled a watershed moment in the development of psychiatric nursing in Canada, but its significance was barely noticed. That this occupation was created in less than a year was remarkable and related to a variety of interacting factors. There had been a government and one medical superintendent who for over thirty years did nothing to obtain trained nurses.[302] The geographically and socially isolated mental hospitals in the province were in a crisis when T.C. Douglas and the CCF Government came to power and something had to be done quickly in the post-war years.

The approach was both pragmatic and idealistic. There was an historical lack of presence of registered nurses in Saskatchewan's mental hospitals,[303] a post-war shortage of nurses throughout the province,[304] an association that was perceived by government to be resistant to mental health reform because it refused to compromise on nursing education standards,[305] and a government insensitive to professional concerns.[306] At the same time there was an adequate supply of untrained mental hospital staff with strong political ties to government, who desired a professional designation.[307] Political ideologies and maneuvering, and a compassionate lawyer who championed social democratic principles for the "underdog" made the leap from untrained attendant to professional nurse a simple one.

Post-war Saskatchewan, as elsewhere in Canada, was a patriarchal society characterized by male authority and female acceptance and even deference to that authority.[308] In relationships, just being male held more authority than being an educated, female registered nurse, even one who was the administrator of an association and a

university professor. Ellis' leadership was limited by her gender. The influence of strong and ambitious male personalities in the likes of McKerracher and Vowles cannot be ignored. Ellis was the sole nurse leader–she was the SRNA, and it was not possible for her alone to overcome these factors.

One Combined Program for Manitoba But Little Else

The War Creates a Shortage of Nurses at the Brandon Hospital for Mental Diseases

As one LeBourdais article pointed out, Saskatchewan and Manitoba shared the distinction of having the worst mental hospitals in Canada.[309] Nevertheless, Ivan Schultz, Manitoba's Minister of Health and Public Welfare achieved some redemption when the *Regina Leader-Post* published an editorial about Premier Douglas' new mental hospital staff training program.[310] He commented:

> I did not know that the Province of Saskatchewan has not been carrying out any training at its mental institutions. In Manitoba we have been training mental hospital nurses and attendants for many years. I will be glad to call the attention of the House to this fact when we are discussing our mental hospitals.[311]

While the population of Manitoba's two mental hospitals and school for the mentally retarded increased through the war years from 2,744 in 1939 to 3,059 in 1945, and to 600 more patients than beds by the end of the decade, the overcrowding was significantly less than in Saskatchewan's institutions.[312] In contrast to Saskatchewan, with its adequate number of attendant and nurse-attendant staff, Manitoba's main problem was a shortage of female students and graduate mental and registered nurses from 1941 to the end of the decade.[313] Ever since Dr. and Mrs. Baragar initiated the Brandon Mental Hospital training school, a high value had been placed on trained female nurses.[314] Almost every

young woman with appropriate qualifications who applied for attendant work was put into the mental nurse training program.[315] Both Drs. Baragar and Pincock insisted on having registered nurses on staff because physical health care for mental patients was considered vital.[316] The training school and milieu so closely mirrored general hospital training schools that when World War II broke out it experienced similar problems. The hospital lost some of its registered nurses to the Royal Canadian Army Medical Corps; mental nurse graduates found opportunities to enter general hospital schools and young women, finding other opportunities, did not apply.[317] From 1941 to 1947 the hospital lost thirty mental and registered staff nurses.[318] For the first time in his ten years as medical superintendent, Dr. Pincock had to hire some untrained female attendants to assist the graduate nurses.[319] Untrained female attendants were so rarely employed at the hospital that Pincock did not know what kind of uniform they should wear.[320] The hospital, like most general hospitals of the day, relied on its student nurses to provide service. There was a twenty year tradition of mental nurse training at the Brandon Mental Hospital and it was this early World War II shortage of students and graduates which became the stimulus for change to the nurse training program.

General Affiliations at Last

While Health Minister Ivan Schultz was able to score political points by advising the Manitoba Legislature that the province was much further ahead in mental hospital training than was Saskatchewan,[321] his government continued to have minimal input into the administration of the three schools and the nurses' training at each. At the Brandon school, nursing administration traditionally had played a central role and it was

nursing that took the lead when the shortage of trained nurses at the hospital became unmanageable.[322]

In early 1942 Katherine Wilkes, Brandon's Superintendent of Nurses and a Winnipeg General Hospital graduate, and Normancelle Burn, nursing instructor, wrote to Gertrude Hall, school advisor and Executive Secretary at the MARN stating:

> Many of our nurses, both students and new graduates have felt the lack of a general nursing course in their instruction here and have gone on to take three more years in a general hospital. It is our belief that these girls might have remained in Brandon if an affiliation scheme with a general hospital was functioning.[323]

Considering the MARN's earlier history with the Brandon institution, Hall was surprisingly responsive to their problem, and negotiated a meeting between these Brandon nurses and Catherine Lynch, then Superintendent of Nurses at the Winnipeg General Hospital.[324] Lynch, of course, was no stranger to the Brandon school or to general affiliations, having established a four-year combined course in Ponoka, Alberta with Dr. Baragar a decade earlier.[325] Wilkes and Lynch also had been colleagues at the Winnipeg General Hospital. Lynch and Medical Superintendent Dr. H. Coppinger agreed to accept Brandon students who had completed two years of mental nurse training, directly into the second year of the Winnipeg General Hospital training program. Following two years of general training the students would receive diplomas in psychiatric and general nursing and would be eligible to write the MARN registration examinations. It was notable that this time around, the MARN Board embraced the new training scheme.[326]

The timing of the request for affiliations with the Winnipeg General Hospital could not have been better. That hospital's nurses were complaining about working

without adequate staff and the board of trustees recommended increasing student enrollment and advertising for students.[327] Further, the CNA had received a grant from the federal government to assist the association to intervene in the war's nursing crisis, and selected schools which temporarily increased enrollment were eligible for grant monies.[328] In other words, the Brandon Mental Hospital affiliation was mutually advantageous to the Winnipeg General Hospital's nursing situation in 1942. It is not known if Hall first asked the Brandon General Hospital to provide the affiliations.

The achievement of an affiliation with the Winnipeg General Hospital was perceived as a landmark in the development of the Brandon school, and Dr. Stuart Schultz, new Medical Superintendent, made it the focus of his annual report:

> This school has played an important part in the changing of an institution giving custodial care into the modern psychiatric hospital of today. In the period 1923-1942, 219 nurses received their diplomas in mental nursing. Several of these girls also entered General Hospitals and received their Registered Nurse diplomas. Both former medical superintendents of this hospital had as their objective affiliations with general hospitals with a view of a combined course. Affiliation with the School of Nursing of the Winnipeg General Hospital was finally consummated in 1942.[329]

Although a two-year general affiliation was one year longer than that in the Ontario mental hospitals' training schools, it was in keeping with the MARN's minimum requirements.[330] Further, it was one year less than what some Brandon mental hospital graduates had been doing on their own to 1942.[331] It was exactly the length that Kathleen Ellis and the SRNA recommended to Dr. McKerracher.[332] However, the combined course in which mental hospital students also received general training, was in McKerracher's words a "failed experiment" because there were never enough students or graduates trained to provide service to the mental hospital.[333] McKerracher discarded this model, whereas the nursing and medical administrators at the Brandon institution embraced the

same plan. McKerracher cited Dr. T. Pincock, Manitoba's Provincial Psychiatrist, as one who did not wish to continue general hospital affiliations;[334] but this seemed unlikely considering what Dr. Stuart Schultz wrote in his annual report.[335] Further, Dr. Pincock constantly stressed that patients in Manitoba's hospitals required both mental and physical nursing care.[336] Physical nursing care for Saskatchewan's mental hospital patients was not viewed as a priority by McKerracher.[337] This affiliation was a jewel among Manitoba's mental hospital training schools.

Training in the Combined Program

In order to meet the MARN minimum standards, students who entered the new combined program in 1942 required a complete grade eleven, junior matriculation (including chemistry), or normal school. No tuition was charged but students were required to spend $25.00 on first year textbooks and $7.00 in second year. Students received board and room, uniforms and laundry and a monthly allowance of $30.00.[338] That allowance increased to $35.00 per month in 1946 and students were reminded to save something each month to cover personal needs for their final two years that were without an allowance.[339] Students entered as a class each September; and whether they were in class or providing ward service, shifts were eight hours in length, six days a week with a three week summer vacation. A five-month probationary term was followed by examinations; and if successful, the students received the school nurse's cap. A 60% average was required for all terms. Lectures were provided by the superintendent of nurses, two nursing instructors, hospital medical staff and a dietician from the Brandon General Hospital. Ward instruction was carried out by nursing supervisors.[340]

A decision was also made to continue offering the hospital diploma course in mental nursing "for the time being at least".[341] But even the diploma course underwent a makeover, with the third year deleted and third year lectures transferred to second year. Therefore all students, whether combined or diploma, took classes together for their first two years.[342] Wilkes and her nursing instructors made this decision because some applicants came with only grade ten and the financial circumstances of others made it unlikely that they could proceed with the affiliation course in Winnipeg. Rather than studying general nursing, they needed to graduate and work at the mental hospital.[343] Many of the latter students wrote and passed the MARN qualifying examinations at the end of second year; but in spite of advocacy by the superintendents of nurses to secure funding so that they could achieve their RN credentials, they remained in Brandon.[344]

First year students received two hours of lectures each day during a six hour shift on the wards and second year students worked eight hour shifts with a one or two hour lecture included. There were a total of 650 lecture hours through the two year course.[345] Theory courses included:

> Nursing Principles and Practise
> Basic Sciences (anatomy, physiology, bacteriology, nutrition, materia medica, pharmacology)
> Principles and Practise of Psychiatric Nursing (mental hygiene, psychology, occupational therapy)
> Medical-Surgical Nursing
> Health Education
> History of Nursing (ethics)[346]

The affiliate students received the following 230 theory hours at the Winnipeg General Hospital training school:

> Orthopedics
> Pediatrics
> Ophthalmology
> Health Education
> Dermatology
> Tuberculosis

Otolaryngology	Venereal Diseases
Gynecology	Communicable Diseases
OR, Anesthesia	Community Health
Nutrition and Diet Therapy	First Aid Nursing
Obstetrics	Professional Adjustment[347]

Clinical experiences included:

Maternity	Medical
Children's Hospital	Communicable (King George)
OR	Diet Kitchen
Casualty	Public Health
Surgical	Private Wards[348]

Whether the students were at the rural mental or urban general hospital, the emphasis was on the service or clinical component of the curriculum. Nonetheless, the Brandon diploma program clearly emphasized more nursing education than did the three-year 500 hour Saskatchewan training program.[349]

Beginning in 1942, the training school brochures noted that student nurses would receive training in special therapeutic procedures including insulin and electric shock, and care for patients undergoing leucotomies, a new brain surgery technique.[350] Electro-convulsive therapy (ect) or electro-shock treatment came into use at the Brandon Hospital for Mental Diseases in January, 1942 and quickly replaced metrazol shock therapy because it was considered simpler than an intravenous injection of large amounts of fluid, and the loss of consciousness was immediate.[351] It was used to treat patients with depression, mania and schizophrenia. Dorothy Cassan's lecture notes included this information about how to provide nursing care to patients receiving ect:

> In order to have a comprehensive understanding of the nurse's role in electro-shock therapy it is necessary to understand the general principles of this treatment:
>
> - the principle of the therapy is the production of a grand mal seizure by the application of an electrical current to the head and its passage through the brain

- the exact method by which this convulsion is beneficial is not yet known
- once the current is applied the patient is immediately unconscious
- there is no pain
- the seizure is not disagreeable to the person undergoing the treatment

Apparatus and Equipment:

- the electric shock machine is a small portable 16 pound apparatus which can be plugged directly into the hospital current. The current is applied through large electrodes placed over each temple
- wooden table with a curved back support and mattress
- tray with mouth gag, gauze squares, electrode jelly, tongue depressors, emesis basin

Procedure:

- saline soap suds enema the afternoon before and shave temples
- treatment is given three times weekly between 9:00 am and 10:00 am
- patient has no breakfast and no barbiturate medications, remove dentures and hair pins
- place patient on the table and put a sandbag under small of back
- apply electrode jelly to the temples with a tongue depressor then cotton pads soaked in saline are placed over electrodes
- apply moderate pressure on shoulders, pelvis, wrists and knees
- insert mouth gag and hold in place
- the machine is then set by the physician and electrodes applied
- the convulsion created is similar to the epileptic seizure
- after the clonic phase has passed place patient in prone position, face down and head to the side to facilitate breathing

Post-Treatment Nursing Care:

- keep a close check on patient's color, pulse and respirations
- prevent patient from striking his head if restless
- remain with patient until fully recovered and offer quiet reassurance
- offer light lunch after session[352]

Beginning in 1943, the student nurses at this hospital were taught how to provide care for patients who underwent prefrontal lobotomies, also known as leucotomies. This was a surgical procedure involving separation of the white matter connecting the frontal lobes of the brain with the thalamus.[353] In an article detailing Brandon's experience with this brain surgery, Drs. Schultz and Evans noted that many of their patients had serious

behaviour problems–often dangerous, violently disturbed, with dirty and untidy personal habits, and destroyed their clothing. Some were in straitjackets. It was believed that the surgery would relieve the patient's mental anguish, improve behaviour and make him a better-adjusted member of the hospital community. These physicians explained that not only was it done to help the patient him or herself; but in the interest of other patients who were upset by such patients, and to assist the nursing staff who carried a heavy burden of care.[354] These principles of nursing care were taught to Brandon students:

- shave hair carefully as abrasions may create infection and contaminate the wound (serious due to proximity of the brain)
- there is a danger of post-operative shock for 24 hours–monitor BP, pulse, respiration and color, record
- wound care following surgeon's orders, make sure bandage is tightly applied as leucotomy patients generally pick at bandages
- incontinence is common, observe for distended bladder and retrain as necessary
- lethargy is common and nurse must stimulate and encourage participation and activity.[355]

The shortage of students and nurses from 1945 through to the end of 1947 necessitated a temporary hold placed on this surgery.[356]

Upon completion of the general affiliation in Winnipeg the Brandon students returned to their home hospital for graduation, at which time they received both the mental and general nursing diplomas and a redesigned nursing pin depicting both programs.[357] Even the location of the ceremony changed from the hospital to a local church, in keeping with general hospital graduations of the day; and the superintendent of nurses from the Winnipeg General Hospital participated in the graduation ceremonies.[358] In 1945 the Blanche Eugenie Baragar Memorial Medal was awarded for the first time to a graduate of the combined course, partially fulfilling Dr. Baragar's wishes. There was no evidence that a second medal was ever awarded to a graduate in mental nursing, as he

requested.[359] These well-prepared graduates were in high demand in both mental and general hospitals, and those who chose to remain at the Brandon Mental Hospital were offered supervisory and teaching positions.[360]

The Brandon Hospital for Mental Diseases nurse training school was considered the bright spot among the three training schools in Manitoba. Dr. T. Pincock, Provincial Psychiatrist, pointed out that it was the only one which used the MARN's minimum curriculum and the only one where students were taught by qualified nursing instructors.[361] He advised that the students and graduates from the Selkirk and Portage schools should not be considered as well-prepared.[362] Further, Health Minister Ivan Schultz proudly announced to the Manitoba Legislature that "the nurses' training school at the Brandon Mental Hospital and its affiliation with the Winnipeg General Hospital is one of the best of its kind".[363]

There had been little progress under Dr. Barnes' medical superintendence at the Selkirk Hospital for Mental Diseases. Unlike Brandon's, the mental nurse training course remained three years in length.[364] The shortage of female staff at both the Selkirk and Portage institutions was even worse than at Brandon, and Drs. Barnes and Bristow (Portage) met with Dr. F. Jackson, Deputy Minister of Health and Welfare, and decided that they could entice more applicants into training if they offered an option for students to take a four month course in practical nursing at a rural general hospital during second year.[365] Credit for the remaining eight months of the one-year practical nursing course was arranged.[366] Dr. Barnes instituted this option to his nurse training course, but Portage's Dr. Bristow reconsidered when he discovered that a licensed practical nurse graduate earned $3.65 per day after just one year of training whereas his graduates were

paid $3.00 daily after three years of training. He did not believe young women would see any advantage in this plan.[367] As in Saskatchewan, the lack of a general nursing presence at these two Manitoba government hospitals meant that psychiatry maintained its traditional tight control of mental nurse training.

Post-World War II and the Shortage of Mental Hospital Nurses Worsens

By the end of the war it became clear that the changes made to the nurse training program were not, in and of themselves, enough to end the shortage of nurses at the Brandon Mental Hospital. In the spring of 1945 there were nine registered nurses, eighteen mental nurse graduates, twenty-three student nurses and thirty-four untrained female attendants caring for 753 female patients, with ninety-five male attendants responsible for 828 male patients.[368] Insulin shock therapy had to be curtailed for periods of time on the female side of the hospital and there were not enough graduate nurses to cover female wards.[369] Nurses were doing so much overtime that they were constantly tired; but even so the superintendent of nurses wondered if she would have to cancel summer vacations.[370] Following a visit to the hospital, Mr. Rice-Jones, Civil Service Commissioner, wrote to Ivan Shultz, Minister of Health and Public Welfare:

> The situation is such that I do not see how it can continue without some untoward incident happening. They are short graduate nurses and student nurses....Both Dr. Schultz and Miss Wilkes state that the situation is far worse than at any time during the War....[Some] of the nurses may leave for the load they have been carrying makes them feel they cannot stand the strain much longer. At times the pupil nurses may be alone on wards with patients....[A] second year pupil was found alone with 70 patients. In my opinion the situation is impossible...nurses run the risk of something happening...serious injury. There is nothing that this office can do to secure nurses at the present rate of pay. We have canvassed every possible avenue and advertised....The fact is that the salaries we are paying for graduate nurses are lower than what is being paid in general hospitals.

> What is the remedy? I have been following the advertisements for general hospital nurses and the rate offered to these girls is $80 plus maintenance, or even $100. We start nurses at $80 less maintenance. We should immediately pay the maximum rate for our nurses. We must be able to compete.[371]

The civil service commissioner's suggestion, although not immediately acted upon, underlined that the shortage of students and graduate nurses at the mental hospital was a reflection of the larger post-war shortage of general hospital students and nurses in Manitoba.[372] The war opened up new employment opportunities for women and fewer young women applied to schools of nursing. There were more possibilities for work within the expanding health care system and students and nurses alike were refusing to train and work under unreasonable conditions, including being underpaid.[373] In the summer of 1945 registered nurses were so few and far between that an outbreak of dysentery at the Manitoba School for Mental Defectives necessitated "borrowing" three Nursing Sisters from the Royal Canadian Army Medical Corps (RCAMC) at Fort Osborne. They were the only registered nurses in Manitoba available to help with the emergency.[374]

Ivan Schultz, Minister of Health and Public Welfare, invited the Rockefeller Foundation to review training programs and facilities for physicians and nurses in Manitoba. Not surprisingly, the main problem identified was the scarcity of nurses. Moreover, just as Dr. Weir found fifteen years earlier, this report criticized the finding that student nurses were still providing the majority of the nursing service in both general and mental hospitals. Some hospitals had no graduate nurses on staff.[375] The report praised the new combined four-year program for mental and general nursing offered at the Brandon Hospital for Mental Diseases, in affiliation with the Winnipeg General

Hospital. Although service-oriented, there was a strong correlation of theory and practise throughout the program.[376]

The *Rockefeller Foundation Report* did not bring about change to the apprenticeship model of nurse training in Manitoba. For the government, hospital boards and most physicians, the answer to the shortage of hospital nurses was simply to find more students to enroll in hospital schools. From 1946 to 1948 both the Brandon General and Mental hospitals were experiencing severe shortages of students and graduates, forcing the general facility to close wards.[377] There were only nine students enrolled in the mental hospital school and it was short two instructors, prompting Health Minister Schultz's admission to the House that "the situation is beyond our control. We are having a terrible time to get female staff".[378]

The minister tried some creative methods to lure potential students to the mental hospital schools, particularly Brandon. Public health nurses were requested to "look for high school girls" in rural Manitoba;[379] and Schultz sent letters to 100 young women who had applied for normal school but were turned away due to excess applicants. He described the differences between each school and included applications.[380] He did not mention the shortage of nurses throughout the province, and indicated that the recipients ought to feel privileged with the invitation to apply:

> There is an opportunity for you in the Civil Service of Manitoba. You could train as a nurse in one of our hospitals....We feel that these are splendid opportunities for you to obtain training in an occupation that will be of infinite value to you in later years, whether you decide to make nursing a career, or to marry.[381]

It is not known if any of these women accepted Schultz's invitation.

Dr. Stuart Schultz, Medical Superintendent, contemplated closing his school,[382] and his colleague at the Brandon General wrote to Ivan Schultz regarding a potential plan to rescue both Brandon hospitals:

> We have a proposal to establish a four year affiliation course in nursing...would involve Brandon General and Mental hospitals....The situation here is not improving. The nurses lost to other training, employment, marriage and retirement is greater than the enrollment in all of our nursing schools. The shortage is a country-wide situation and all hospitals find it impossible to provide service unless we have an adequate supply of student nurses. Our superintendents of nursing talked with Miss E. Russell, Director of Public Health Nursing...said it would be impossible to find enough qualified nursing instructors for each of these hospitals...the student nurses could take all of their lectures together. She advised that in order to attract more students into the nursing profession and to retain their services, working conditions and salaries have to be commensurate with that of other professionals.[383]

It was revealing that Elizabeth Russell's self-evident advice was deemed important enough to communicate to the minister. Nurses had trained and worked under poor conditions for decades and Dr. Weir's survey had confirmed this view of their situation.[384] However, their situation was not attended to until changes created by the war forced others to begin to take notice. Even the CNA leadership could do little to change nursing education and practise until the association raised its political profile during and after the war.[385] A Winnipeg newspaper reported on general hospital training conditions:

> Menial tasks, restrictions, no pay for students, enforcement of rules all drew a measure of criticism in a survey of training conditions in Winnipeg. Since the 19th century the rigid discipline and training has undergone little change. Public opinion, discontent of students and graduates has resulted in considerable protest across the country that nurse training is outdated. Nurses point to a secretary who they say earns as much or often more than a graduate nurse. She studies only 6 or 12 months and is not bound by rules on her off-duty hours. She is not confined to two nights off per month with one late pass per week until 11pm. No wonder girls are taking business courses instead of entering the profession. Asked their opinion of what caused this acute nursing shortage in Canada hospital authorities in Winnipeg admit that many girls dropped

> out of their courses because of "conditions". "Improve conditions and there won't be any shortage" nurses chorus right back. "We even have to pay for things we break–it's petty". Breakage authorities reply, can become a habit. Payment for articles broken is felt to be a deterrent of carelessness and an encouragement to the student to be careful. A common complaint of the nurses is that other professions do not have to perform menial tasks such as dusting, cleaning and bed-making. However one Winnipeg official said that student nurses have need of training in cleaning and dusting toward the thorough care and comfort of her patient. Even despised flower-fixing was defended by the official....It is admitted that less than 10 percent of Winnipeg high school girls applied for nurse training last year and in the same period the demand for nurses increased by 60 percent. The result is that most Winnipeg hospitals are operating with 75 percent of normal staff.[386]

Reciprocal Affiliations for Brandon's Hospitals

The agreement between Brandon's two hospitals for reciprocal affiliations was realized in 1949, and in approving the agreement the MARN Board of Directors noted that "the development and implementation of this plan will be of great interest to all nurses in Manitoba".[387] Reciprocal affiliations were exactly what Drs. Baragar, Mathers and Pincock had proposed to the MARN from 1925 to 1935, but it took the post-war shortage of students and instructors and imaginative work by Elva Cranna, new Superintendent of Nurses at the mental hospital, along with A. Crighton, her colleague at the Brandon General, to make it a reality.

This was a true affiliation for the mental hospital students and not the "two plus two" plan which the mental hospital was then offering with the Winnipeg General Hospital. The students received one year of mental nurse training, two years of general training at the Brandon General, which included obstetrics at the Grace Hospital, pediatrics at the Children's Hospital, tuberculosis nursing at the Ninette Sanatorium and back to their home school for a six month term prior to graduation. Cranna wiped out six

months of service, making the program just three and one half years.[388] She was able to do so because the Brandon and Grace students provided service during their three months affiliation at the mental hospital.[389] Bringing the Brandon Mental Hospital students back to their home hospital for the final six months was advantageous for the students and hospital alike. The students received their monthly allowance for that term and the hospital received the service of students with two years general training. It was believed that reacquainting students with their home hospital would encourage them to stay and work there following graduation.[390] Besides its being a shorter program and providing a final term allowance, there were other advantages for the students. The Brandon General Hospital offered a small monthly allowance identical to that given to their own students, and Brandon was closer to home than Winnipeg for most of these rural students.[391]

The revised program was an instant success for the mental hospital. It began attracting more applicants than it had for most of the decade; but at the same time applications for the shorter mental nurse diploma program almost ceased.[392] Superintendent of Nurses Julia Ryfa believed this occurred because young women saw more opportunities in having the combined course rather than the mental nursing course alone.[393] For instance mental nurse graduates without the RN diploma were refused entry into post-graduate nursing courses at McGill University.[394]

Brandon Mental Hospital students who were already affiliating at the Winnipeg General Hospital completed their two years, and at the end of 1951 these two hospitals terminated their four year program.[395] Over nine years thirty-one students graduated from this program and Bertha Pullen, Superintendent of Nurses at the Winnipeg General

Hospital, though supportive of their relationship with the Brandon institution, believed it was advantageous for the two Brandon hospitals to have a reciprocal program.[396]

By 1949 the worst of the nursing shortage was over at the Brandon institution. Besides the shorter reciprocal program with the Brandon General Hospital, other incentives caught the attention of young women. The allowance was doubled to $65.00 monthly in the first year and $75.00 in second year, making it somewhat easier to complete the general portion of the training program.[397] Vacations were increased to four weeks and student nurses could join the civil service superanuation plan. The plan was made available to them as an incentive to remain with the hospital following graduation.[398] Advertisements for the new program were placed in Brandon and rural newspapers, and in the autumn fifty student nurses enrolled.[399] Graduate nurses' salaries were also raised, an action which brought in five more registered nurses. And for the first time since the Depression, registered nurses enrolled in the school's psychiatric nursing post-graduate course. The nursing instructors deleted six months of service from Dr. Pincock's former course, making it a six-month, 172 hour course.[400] At the spring graduation both Health Minister Ivan Schultz and Dr. Pincock shared their optimism that conditions at the hospital were turning around.[401] Part of their optimism was the result of new monies announced from the National Health Grants Program, some of which was used to support improvements in nursing education, including the employment of more instructors.[402]

Brandon's Male Attendant Training Program

Male attendant training at the Brandon Hospital for Mental Diseases had always been regarded as less important than the training of female nurses, and although there were some changes made in the 1940's, it continued as a low priority.[403] The male attendant lecture course remained separate, optional and spread over three years, at the end of which the men received a certificate in mental nursing.[404] Early in the war, twenty-two attendants enlisted in the Royal Canadian Army Medical Corps and served as non-commissioned officers. Because their positions were filled by conscientious objectors, the "male side" of the institution carried on without the shortage experienced on the "female side".[405] Although the attendants' ward work fell under the direction of the chief male attendant, Superintendent of Nurses Elva Cranna finally rescued male training from the hospital physicians and placed it under her supervision in the training school. It became a mandatory course, with grade ten required and 200 hours of lectures over three years.[406]

In 1948 attendants at the Selkirk and Brandon Mental Hospitals attempted to form a hospital union, creating much angst for Premier Stuart Garson's Progressive Government. The attendants' leader was Alfred (Alf) Barnett, who later organized Manitoba's psychiatric nurses' association.[407] Ivan Schultz, Minister of Health and Public Welfare, outlined his findings on the union attempt to the Premier:

> Enclosed is a copy of the proposed agreement submitted by the Canadian Congress of Labour to be used to organize the union at the mental hospitals. I understand this is based on a similar agreement now operating in Saskatchewan but not anywhere else in Canada. There would be difficulty operating our mental institutions under this agreement.[408]

Dr. Pincock, Provincial Psychiatrist, advised Schultz that he did not want the mental hospitals "controlled by attendants" because patient care would suffer.[409] The provincial

government remained opposed to trade unions and the issue disappeared for the remainder of the decade.

Psychiatric Nursing Education for General Students

The Winnipeg General Hospital's affiliation with the Winnipeg Psychopathic Hospital continued as a well-established learning and service experience for its student nurses. Throughout the 1940's most students received an eight-week clinical posting, including male wards, and twenty-four lecture hours.[410] The Psychopathic Hospital had its own nursing instructor but Dr. Pincock and his medical colleagues continued to deliver most of the lectures. Margarita Silver, a retired Brandon Mental Hospital graduate, related that medical psychiatry's traditional ownership of education for psychiatric nursing had a long-lasting influence at the Winnipeg General Hospital. For example, when she began teaching psychiatric nursing at the Winnipeg General in the early 1960's, some psychiatrists questioned how a nurse was qualified to teach in this specialty.[411]

By the mid-1940's six other schools of nursing in Winnipeg had arrangements with Dr. Pincock and his Psychopathic Hospital staff to receive the same lecture series as was given to the Winnipeg General Hospital students.[412] However, these schools did not offer their students a psychiatric nursing affiliation and it was the end of the decade before any other Manitoba general hospital students affiliated. Both the Brandon General and Grace Hospital in Winnipeg established reciprocal arrangements with the Brandon Mental Hospital. Their students received twelve-week affiliations which included three hours of daily lectures.[413] In Saskatchewan, general hospital students were denied mental

hospital affiliations, so this was an encouraging development for some Manitoba student nurses.[414]

While the topic of education for psychiatric nursing consumed a huge portion of the SRNA's agenda in the 1940's, the same did not occur with the MARN. Gertrude Hall, MARN's student advisor and Executive Secretary, had completed a three-year study on the status of nursing education in Manitoba and the association focused on implementing recommendations from her report.[415] And as was the case in Saskatchewan, the post-war shortage of registered nurses, particularly in rural hospitals, required attention.[416]

The Manitoba study revealed a lack of uniformity in standards between Manitoba's sixteen schools of nursing. For example, one school taught sixty-six hours of theory over three years while another taught 653 over the same period. One school offered no classes in nursing principles and another gave 176 hours. Some schools did not employ any qualified nursing instructors, and most often ward "experience" simply meant hospital service. Three schools did not have a designated classroom and one school lacked a blackboard. In some small hospitals students remained poorly housed, sometimes in attics. Hall was deeply concerned that the majority of the sixteen hospitals had not changed the way students were taught for over a generation, and described education and service as "entangled".[417]

The MARN set new minimum standards and a curriculum for Manitoba schools, and instituted first year qualifying examinations.[418] Psychiatric nursing was allocated a minimum of ten theory hours as a topic within a medical nursing course. The content was tested on registration examinations. An eight-week affiliation for clinical practise was optional.[419] Nettie Fidler, then teaching in the School of Nursing at the University of

Toronto, spoke to a MARN general meeting about the importance of psychiatric nursing affiliations for all student nurses in the province.[420] However, since clinical experience in this course remained optional, there was no movement by hospital schools of nursing toward Fidler's vision.

At the height of the nursing shortage at Brandon's two hospitals, Carolyn Wedderburn, Assistant Superintendent of Nurses at the mental hospital and President of the Brandon Graduate Nurses' Association, wrote to the MARN Board urging psychiatric affiliations for students, and argued for making this a requirement for registration. It was obvious to her that the two had to go hand-in-hand.[421] A short time later the MARN superintendents of training schools committee requested a stand-alone psychiatric nursing theory course in the curriculum, and recommended that all Manitoba student nurses be offered an elective affiliation at a mental hospital.[422] Like the superintendents of nurses, the MARN Board was unwilling to commit to mandatory psychiatric affiliations. A revised minimum curriculum recommended a twenty-five hour psychiatric nursing theory course in second year, but clinical practise remained optional.[423]

In Saskatchewan the SRNA was shut out of mental hospital affiliations for general students by Dr. McKerracher, but such was not the case in Manitoba.[424] Dr. Stuart Schultz, Brandon's Medical Superintendent, was pleased that the Grace and Brandon General students had commenced affiliations.[425] And Dr. T. Pincock, Provincial Psychiatrist, invigorated from a trip to Ottawa to attend the federal government's first Advisory Committee on Mental Health meeting, announced to the Deputy Minister of Health, Dr. Jackson, that he wanted all general students to affiliate to Manitoba's mental hospitals, and suggested this would be possible if more nursing instructors were hired at

these hospitals.[426] Attendees at the Ottawa sub-committee meeting on training recommended psychiatric nursing clinical education for all student nurses and Pincock embraced the idea.[427] However it was unlikely that the Winnipeg Psychopathic Hospital had the capacity for more affiliate students; and the Selkirk Hospital for Mental Diseases did not have instructors or a nursing curriculum. The Portage School for Retardates did not care for psychiatric patients, which meant that the Brandon Hospital for Mental Diseases would have had to accommodate the majority of Manitoba's general nursing students.

At the close of the decade nursing in Manitoba was slightly further ahead than Saskatchewan in achieving psychiatric nursing affiliations for general students. Student nurses had a strong presence in two provincial mental health facilities. However, these developments occurred without the MARN's direct assistance. Carolyn Wedderburn urged the MARN to promote registered nursing for care of the mentally ill, but the Board displayed little leadership concerning her request or the issue generally.[428] Further, there was no evidence in the MARN Board minutes that it had discussed the Saskatchewan situation or even that it was aware of the new legislation. Pincock was enthusiastic, but it was incumbent upon the MARN Board to work with Dr. Jackson, Deputy Minister of Health and Public Welfare, to improve nurse training resources at the Selkirk institution, thereby opening the door to more psychiatric affiliations for Manitoba students.

Memories of Some Retired Brandon Hospital for Mental Diseases Graduates

Like their North Battleford sisters, the retired Brandon Mental Hospital graduates grew up in towns or on farms close to Brandon–Portage la Prairie, Sifton,

Bowsman and Griswold, and a few identified Brandon as home. Hospital records verified that most student nurses who trained at this hospital in the 1940's moved from farms and towns in southwest Manitoba–Shilo, Neepawa, Gladstone, Minnedosa, Dauphin, Virden, Rivers, Gretna, Pilot Mound, McCreary, Rapid City and Brandon.[429] As in the first decades of the school's existence, very few came to the hospital from Winnipeg or outside the province. Margarita Silver (Homesen), a 1945 graduate, commented that "all of us were small town rural Manitoba girls, young and very naïve".[430]

As in the previous decades most of the retired Brandon graduates were white Anglo-Saxon Protestants. Several identified a Scottish heritage. Their family names included Higgs, Mercier, Murison, McKay and Dennis. Of the group only Margarita Homesen was not born in Canada. As a toddler she and her Mennonite family immigrated to Canada from the southern Ukraine.[431] Two of the women had parents who came to Manitoba as homesteaders.[432] Hospital documents indicated that throughout the decade the majority of Brandon's student nurses shared a similar heritage.[433] At the end of the 1940's there were more students enrolled with Eastern European family names but they were in the minority.[434]

Much like the North Battleford nurses, all of the Brandon retired graduates described their parents as working class, and two noted that their families fell into poverty during the Depression.[435] Without fail they indicated that their decision to enter the training school at the Brandon Hospital for Mental Diseases was related to their families' inability to support them financially in any other educational pursuit after high school. Each recalled the same $30.00 monthly allowance as being "the" motivating factor. Margarita Silver (Homesen) described how she had excelled through school and

desired to study archeology at a university. However, the physician in her community advised her parents about the Brandon training school, and she slowly came to terms with the fact that it would be the only way she could continue her education.[436] Madeline Whyte (Mercier) and Jessie Little (Murison) wanted to become registered nurses but explained that enrolling at the Brandon General Hospital or in a Winnipeg training school was simply not an option because buying uniforms, paying for breakage and having no spending money for three years were barriers. Both clarified that if they had not gone into training at the mental hospital they would have been forced to seek employment elsewhere. Both Whyte and Little enrolled at this school with the specific intent of going on for general training at the Winnipeg General Hospital.[437]

Unlike the North Battleford retired nurses' experiences, the Brandon nurses' families supported their daughters' decisions to train at the Brandon Hospital for Mental Diseases. Perhaps the fact that the hospital had been operating a well-regarded school for twenty years contributed to these parents' comfort. Madeline Whyte (Mercier) thought that the beautiful nurses' home with running water, elegant white entrance pillars and linen tablecloths in the dining room impressed her parents. She believed that this residence was nicer than most of the students' family homes.[438]

The retired Brandon graduates recalled mostly fond memories of their training days. Except for the black stockings and black heavy shoes, they were proud to wear the blue uniform with its white bib and apron. Barbara Marshall (McKay) and Jeanette Young (Higgs) described how the full uniform was required attire in the dining room, even during time off.[439] As at most general schools, a capping ceremony was held at the end of the six-month probationary term.[440] Following a month of classroom lectures and

demonstrations they were sent to the wards for several hours daily. They recalled that on the wards it was supervisors and senior students who helped them learn the "how to's". A nursing arts teacher sometimes visited them on the wards.[441] Several described early months of doing little else except bed baths and spoon-feeding elderly patients.[442] Lectures were held in the late afternoon near the end of the day shift. Those assigned to the evening shift were required to come to class before work and students on the night shift left their beds to attend lectures.[443]

Most of the retired nurses mentioned "the procedure manual" and Margarita Silver still had her copy. This was the Winnipeg General Hospital's nursing arts course manual which was adopted by the Brandon mental hospital school in 1941 as a key resource for the new combined program. Much of the preparation for their affiliation centered around this manual and its detailed procedures. It held great significance among this group of retired graduates.[444]

Jeanette Young said that even with eight-hour shifts the work was heavy, due to both a shortage of nurses and the nature of the ward work. She said that in her second year she was alone on a night shift with 120 female patients and felt afraid. She confided that although they were then reluctant to admit it, "fear was a common experience amongst my classmates".[445] Madeline Whyte recalled seeing nurses and student nurses treat patients unkindly, for example shouting at patients, shoving them around, and force-feeding. It deeply concerned her but "nothing could be done about it". She now believes that this was patient abuse, but reflected that it was probably a product of the severe work conditions.[446]

The retired nurses had stories to tell about the once weekly bath day, or as Margarita Silver called it, "hell day" because of its degrading assembly line routine.[447] Many patients were stripped and lined up near the tub room. As one patient was removed from the tub, rinsed with a spray and quickly dried, another was put into the same tub. The taps were left on because there was no time to allow the tub to empty and refill with fresh water. Other nurses were assigned to prepare and distribute "bundles" to clean patients. These consisted of a hospital-issued cotton house dress, underwear and cotton stockings (which never stayed up). And still other nurses assisted the patients to quickly get dressed.[448] Barbara Marshall equated bath day with a car wash on a busy Saturday.[449]

Some of the retired Brandon graduates believed that they spent too much time cleaning the wards and that cleaning was a preoccupation of most of the staff. There was a check-list of items to clean on each shift.[450] Margarita Silver and Madeline Whyte mentioned scrubbing tile floors and washing walls.[451] Jeanette Young recalled that some parts of the nurses' office had to be cleaned even before the doctors came through each morning.[452] All recalled the heavy polishing "blocks" used on the brown linoleum floors and how patients were directed to push these blocks in order to wax and shine the floors, something like a "human floor polisher".[453] Silver and Whyte noted that there was also cleaning to do at the Winnipeg General but not to the same extent as at Brandon.[454] Silver said she always wondered "why the hospital didn't just hire cleaning staff and then I could have done more patient care".[455] There was regret and even guilt expressed around their patient Winnie, whose job it was to clean urine and feces from the floors on one ward, day and night. She carried a mop and bucket around, and during the night the nurses woke her up if the floor needed her attention.[456]

The retired Brandon graduates were among some of the first Manitoba mental hospital nurses to assist with electro-convulsive treatment, commonly called shock treatment, and surgical leucotomies. Margarita Silver and Madeline Whyte explained that when they were providing physical nursing care to patients having these treatments as well as insulin therapy, they felt more like "real" nurses.[457] They recognized that most patients were very afraid of electro-convulsive treatment, but at the time they didn't give it much thought. Silver pointed out "at that time we only had a few sedating drugs– chloral hydrate and paraldehyde and there was no alternative".[458] The common recollection was the dramatic seizure and patients being wide awake as the seizure was induced. Whyte was blunt: "The treatment consisted of electricity and a seizure, that's all".[459] Jessie Little was less harsh: "You had to remember that you were doing the best with what you had at the time".[460] The nurses recalled that they were taught to care for patients having leucotomies as they would for any patient undergoing surgery.[461] Madeline Whyte and Jeanette Young smiled at the difficulty they had shaving patients' heads pre-surgery.[462] Silver believed that some patients were less violent after this procedure, and "we could care for them with some compassion instead of being terrified".[463]

The Brandon nurses explained that no matter what nurses did or what treatments were given to patients, it was very difficult to develop any sort of meaningful relationship with them.[464] Silver clarified that nurses were taught to be kind and pleasant with patients but there was no instruction given on "therapeutic communication". She said that even the psychiatrists did not talk with the majority of patients, other than superficial comments as they walked through the wards.[465]

The Brandon nurses also had time for play, though most of their time off was spent on the hospital grounds. They recalled baseball, picnics, tennis, curling and skating. They took occasional bus trips into Brandon for shopping.[466] The majority of their free time was spent in the residence with other students and several developed friendships which spanned fifty years. Barbara Marshall described residence life as "closer than family life".[467]

The Brandon nurses believed they had been well-prepared to make the transition to the Winnipeg General Hospital. Some perceived that they were a little more mature than their classmates at the Winnipeg General because they had been in training for an extra year.[468] Jessie Little and Margarita Silver recalled that it was difficult separating from their Brandon classmates, and those who could not go into Winnipeg felt hurt.[469] Their new classmates accepted these affiliate students and included them in their activities, yearbooks and so forth.[470] Their new nursing instructors treated them fairly– "just like the other students".[471] Several of the nurses recalled that the Winnipeg General Hospital students looked to them for help with learning intramuscular injections because they had a lot of prior experience.[472]

There were some differences from their home school. Everyone seemed more formal with one another and they were required to attend a morning scripture reading before going to the wards.[473] There were less demanding cleaning chores. Jeanette Young recalled some anxiety and awkwardness caring for male patients because she had spent most of the prior two years with female patients.[474] Madeline Whyte and Jessie Little pointed out that it didn't matter which hospital they were at because "patient care was patient care and we were nursing".[475] And as Margarita Silver recalled: "We practically

bowed to the doctors at both hospitals".[476] Margarita Silver and Madeline Whyte commented that even though they had saved from their monthly allowance in order to have some spending money at the Winnipeg General, they lived on about $10.00 a month for two years. It was enough for grooming supplies, stockings and an occasional lunch downtown.[477]

The Brandon nurses described how obtaining their registered nursing combined with mental nursing helped a great deal in developing their nursing careers. Madeline Whyte nursed at the mental hospital for several years before moving into public health and studying for a nursing degree. She thought that without her registered nurse designation she would have remained at the Brandon institution.[478] Jeanette Young also moved into public health;[479] and Margarita Silver worked in both general and psychiatric nursing administration and education, eventually becoming the supervisor of psychiatric nursing at the Winnipeg General Hospital.[480] Jessie Little remained at the Brandon facility and over her career held a variety of administrative positions and led the development of the hospital archives and museum.[481] The North Battleford retired nurses also had successful careers, but all remained at the home institution. These Brandon graduates with the combined course had a variety of career options opened to them.

Summary of the Manitoba Case

In Manitoba, the shortage of students and nurses at the mental hospitals throughout the 1940's was a reflection of the overall provincial nursing shortage but also was amplified by the severe conditions at these institutions. The long-standing lack of MARN and government involvement, and an inconsistent approach to psychiatric nursing

education in this province, led to each mental hospital developing its own unique method to deal with the shortage of students. For instance, Selkirk students could achieve the mental nursing diploma and practical nursing certificate over three years; while just six months longer gave Brandon students both the mental and general nursing diplomas.

The recovery of the Brandon Hospital for Mental Diseases training school at the end of the decade was due to some creative work by two superintendents of nursing and nursing instructors. It was tilting toward the Ontario model. However, this was only one of three training schools, and the lack of a general nursing presence at the remaining schools meant a continuation of the traditional medical control of mental hospital nurse training, much like the case in Saskatchewan. And while the SRNA's Kathleen Ellis displayed advocacy and leadership around the psychiatric nursing education issue, MARN leaders did not. Mental hospital affiliations for some general hospital students in Manitoba developed in spite of this leadership void.

Ontario Nursing Leads the Movement to Psychiatric Affiliations

World War II and Deteriorating Conditions at the Ontario Hospitals' Schools

As in the situation in Saskatchewan and Manitoba, the Second World War found the Ontario mental hospitals overcrowded by about 3,500 patients.[482] Early in the war years, the province's seven mental hospital schools and nursing staffs recruited and retained enough students and graduates to cope with the high patient numbers; but as in Manitoba, by war's end their numbers also dropped. For example, at the Ontario Hospital, Hamilton, there were forty-five registered nurses and forty-one student nurses in 1943; but in 1945 while there were still forty-five registered nurses, student enrollment

decreased to just nineteen throughout all three years.[483] Over those same years the patient population grew by 500.[484] Facing 146 unfilled student nurse positions for the fall, 1945 Ontario mental hospitals' nursing class, Dr. J. Phair, Deputy Minister of Health, decided to bring Ontario's need for mental hospital students to the attention of his colleagues in Manitoba, Saskatchewan and Alberta:

> It is quite possible that the Western provinces are having the same difficulty in regard to nurses-in-training but even if a few applications were received for each school it would assist greatly in keeping our schools open during this year, which will probably be the worst so far as the shortage of applicants is concerned.[485]

Phair's colleagues might have been surprised at Ontario's desire to poach eligible students from their provinces. However, while some Ontario Hospital, Hamilton, students did come from Western Canada throughout the 1940's, the results of Phair's request were unknown. In fact, Dr. Phair might have had more success recruiting students by studying the recommendations from Laura Fitzsimmons' survey of the Ontario mental hospitals' training schools.

Dr. Bernard McGhie, Phair's predecessor, had arranged for Ontario to be included in the American Psychiatric Association's survey of nursing education in American mental hospitals. Although McGhie required no convincing about Laura Fitzsimmons' ability to conduct the survey, such was not the case with some of his medical superintendents. In a letter to the American Psychiatric Association McGhie wrote:

> I would like an outline of Mrs. Fitzsimmons' training and experience in order to convince my medical superintendents that she is capable of advising them with respect to nursing education matters in our Ontario hospitals.[486]

Fitzsimmons' qualifications met with the psychiatrists' approval and her survey pointed out the following:

> It is pleasing to note the many evidences of the efforts being made to give a high type of nursing care to patients. The outstanding problem is overcrowding. The next problem is the lack of personnel....Considering the depleted staffs, the hospitals were outstanding in cleanliness. A very happy atmosphere for patients prevailed. Noteworthy was the lack of mechanical restraint....It is remarkable that during the war emergency an effort is being made to place staff on an eight-hour day....The seven training schools have a total enrollment of 203 students, a decline of 50 percent since the beginning of the war effort. The major portion of the Ontario Hospitals' nursing staff has been recruited from these schools. The decline is due in part to the war situation, but in some aspects, the schools have not kept pace with the schools in the general nursing field. The weakness is in the clinical supervision rather than in the classroom. The curriculum is very good. Generally, the men's service is under the direction of an attendant...line of demarcation between male and female services is a handicap because students lose men's experience....
>
> Recommendations
>
> 1. The school of nursing and nursing service in each hospital be centralized under a superintendent of nurses...provide male experience for students.
> 2. Place greater emphasis upon educational aspects and less on service.
> 3. Take measures to increase the enrollment.
> 4. Strengthen clinical teaching by appointing a clinical instructor to each school.
> 5. Increase the number of RNs on staff.
> 6. Train and utilize more subsidiary workers to assist nurses.[487]

In addition to the overall recommendations, each training school received an individual report. Dr. McGhie wrote a memo to himself following a discussion with Fitzsimmons about her findings:

> Our training schools for nurses are in a rather sorry plight and not only because of war conditions....Unless we raise our standards our schools may deteriorate to the point of non-existence. She is strongly of the opinion that mental hospitals should operate training schools as long as satisfactory conditions are in place.[488]

Saskatchewan's Dr. McKerracher had cited Fitzsimmons as one person who was against mental hospital nurse training schools, but perhaps this was related to the unsatisfactory

conditions in that province's mental hospitals, including the absence of instructors.[489] However, McKerracher was known to manipulate information to serve his needs. McGhie appointed Dr. Clark, a government psychiatrist, to chair a committee of medical superintendents to study Fitzsimmons' recommendations. Superintendents of nurses were not included.

From the start the psychiatrists decided that Fitzsimmons' findings were wrong and that the shortage of students applying to their schools was related to war conditions and nothing more. They disagreed with the idea of hiring nurses' aides because they feared such employees would soon take the place of their registered nurses.[490] And for over six months the physicians got stuck on Fitzsimmons' recommendation to centralize all the nursing service under the superintendent of nurses, so that male and female patients would have equitable nursing care. The committee agreed to the concept in principle only and requested feedback from all medical superintendents.[491] Of thirteen, nine were opposed and four were in favour. Those who wished to retain the status quo commented:

> Is the Province willing to pay a higher per diem for what can bluntly be termed "atmosphere"? It must be recognized that the Anglo-Saxon race will not accept a matriarchal way of life. If the hospitals hope to secure a desirable type of male attendant, the opportunities must be attractive. One cannot visualize an ambitious young man accepting a position with the knowledge that he will be completely and permanently under the direction of a woman.[492]

> At Woodstock male TB wards are supervised by females. Superficially it appears satisfactory but there is a constant undercurrent of resentment. It can also be said that the services of a Chief Male Attendant are missed. It is scarcely conceivable that the time will ever come when a woman nurse can supervise every ward in a mental hospital and if a female nurse is going to supervise a male ward from her locked office, this is unsatisfactory.[493]

> In the past 20 years there has been a retrograde movement in regard to the quality of nursing, particularly in general hospitals but also in our own. There has been too much of a tendency for the medical profession to regard nursing as a distinct and separate profession which is capable of handling its own affairs...calling in the medical profession only when some emergency comes up which they are incompetent to handle...some sort of a junior doctorate who will eventually carry the battle into the field occupied by physicians and surgeons. In the Ontario Hospitals during the time that I was Inspector the quality of care on the mens' sections was superior to that on the other side....I would be inclined to think that the Director of Nursing should be a physician rather than a nurse.[494]

Dr. George Stevenson, Medical Superintendent at London's mental hospital and a longtime champion of the nursing profession and equality of nursing care for male patients, suggested that Fitzsimmons' recommendation for centralized nursing become the Ontario government's post-war policy.[495] Finally another meeting of all the medical superintendents was called to review the feedback and come to some decisions on Fitzsimmons' report. Clark reported little progress from his committee's perspective. The physicians agreed that the training school at Orillia should close because of a scarcity of applicants.[496] The remainder of the meeting was taken up with discussion on the centralized nursing service recommendation. Drs. Stevenson and Farrar spoke in favour, but Drs. Fletcher, Cumberland and Clark argued that it would be dangerous for females, the language would be disturbing for young female students, and the male attendants would resent working under female nurses. It was a lengthy debate and "no definite decision was reached".[497] It was clear that for some of these physicians the idea of educated female nurses who held some authority was a threat to the mental hospital hierarchy and the status of male attendants. They were preoccupied with the gender of the attendants' supervisor rather than the looming mental hospital nurse shortage. Dr. McGhie was embarrassed by the lack of progress around Laura Fitzsimmons' work in

Ontario; and following his sudden death, Dr. J. Phair inherited the identical training school problems.[498]

Phair and his medical superintendents assumed that once the war ended enrollment at the then six mental hospital schools would return to 1939-1942 levels.[499] As Fitzsimmons predicted, this view was wrong. As in Manitoba, the early post-war years saw a continued drop in enrollment. In the fall of 1945 two schools reported no first year students and Hamilton did not have enough students to form a class in 1947.[500] Graduate nurses also began leaving the mental hospitals for rising salaries at general hospitals and soon there were over 200 registered nurse vacancies.[501] Phair reported that the drop in enrollment combined with the depletion of graduate nursing staff was his priority post-war problem.[502]

Two years after Fitzsimmons recommended that mental hospital training school conditions needed attention, the medical superintendents finally agreed with Phair that more untrained nurses' aides were required. However, they stipulated that such employees should have as much high school as possible and that the term "nurse" should only be used for registered nurses.[503] They decided that it was a hopeless endeavour to compete with the large general hospital schools, but that they would carry on even with low enrollments.[504] At the same time, the government increased registered nurse starting salaries at its mental hospitals to $1,200.00 per year, $200.00 less than what most general hospitals in Toronto and Hamilton were then paying.[505]

Ontario Nurses Awaken to the Need for Psychiatric Affiliations

While the superintendents of nurses were conspicuous by their absence as plans were being made for saving their mental hospital schools, they were not silent. Ella Smith, Superintendent of Nurses at the Ontario Hospital, Kingston and an RNAO Board member, was concerned about the quality of patient care and what the post-war years would hold because fewer students chose to train at the Ontario mental hospital schools. She believed it was imperative to include psychiatric nursing in the RNAO minimum curriculum, including mandatory mental hospital affiliations for all students.[506] Since the beginning of the war, there had been no further affiliations organized by Ontario's general hospital schools; and the work done in the late-1930's by Esther Rothery, the Ontario mental hospitals' first supervisor of nurses, had been put on hold. Smith appealed to her fellow Board members to begin dealing with the mental hospital nursing shortage.[507] A few months later, at the RNAO's 1945 annual meeting, the theme was "the place of mental nursing in the reconstruction period". The meeting was chaired by Nettie Fidler, nursing professor at the University of Toronto's School of Nursing, and 700 nurses in attendance heard speaker after speaker explain the urgency of the mental hospital situation and challenge them to action.[508] Dr. George Stevenson, Medical Superintendent of the Ontario Hospital, London, laid the groundwork:

> This new interest is due not only to an increasing recognition of the importance of this subject but also to a changing concept of the emerging close relationship between physical and mental aspects of health. The medical and the nursing student are no longer well-trained unless they are conversant with the psychological factors in disease....The lack of interest of the nursing profession in mental illness and their employment in such small numbers makes them a relatively unimportant group....I would emphasize the responsibility of the medical and nursing professions...not divided into physical and mental care. I would recommend it for your serious consideration.[509]

Laura Fitzsimmons finally had a chance to share her observations with Ontario nurses:

> That mental hygiene should be a part of all nursing is a fact too elementary to need mentioning, yet, strange as it may seem, all too often mental health has been more conspicuous by its absence than by its presence in nursing curricula. For years we have talked of well-rounded programs for student nurses, yet with more beds in the United States occupied by mental patients than by all others combined we have fourteen states that give no courses in psychiatric nursing. What does this mean? Many of our mentally ill are being cared for by people untrained in psychiatric nursing....This should make us hide our faces in shame at the job we have done or rather failed to do. In the thirty-four states teaching psychiatric nursing the usual course is an 8 to 16 week affiliation....What provisions are we making for the thousands of soldiers discharged? How will we, as nurse educators, meet the problem? We need to use the psychiatric hospitals for affiliate courses...nurses of the future cannot afford not to have this experience. It gives students an introduction and many nurses will seek it out following graduation. The chief handicap to the realization of this goal is a lack of competent leaders in psychiatric nursing to establish and direct such courses....With large numbers of patients, few registered nurses and budgets too low to employ more trained nurses, mental hospitals have traditionally depended upon untrained or minimally trained attendants. Plans are underway in the United States for a standard curriculum to license practical nurses or psychiatric aides for mental hospital work....The need for psychiatric nurses is so great that it cannot be over-emphasized.[510]

Hilda Bennett, also a nursing professor at the University of Toronto, was the most direct and echoed the message which Ella Smith had brought to the RNAO:

> Our few psychiatric hospital schools do not graduate sufficient nurses to provide adequate staffs for their own needs or for general hospital units. As professional nurses we must realize that the care of psychiatric patients is our responsibility. Psychiatric nursing is as old as nursing but we have not included it as an integral part of our teaching in general nursing. Forty-one of 59 general schools in Ontario have no psychiatric affiliation. We must be convinced that psychiatric nursing is not a separate specialty but an integral part of general nursing. In essence that concept is taken from the proposed curriculum for schools of nursing in Canada....In three years we could have 5,000 nurses who have affiliated to psychiatry. Gradually the psychiatric hospital schools would be eliminated. We need to make an urgent demand for the clinical field to be broadened but the demand for affiliations has not yet taxed the available mental hospitals. It is not for the psychiatric hospital schools to go to the general hospitals to

> try to sell their field. It is for the general hospitals who so sorely need that experience to go to the psychiatric hospital with this plea. Should we not accept this as a challenge?[511]

Bennett clearly pointed out that the onus was on the general hospital schools of nursing to arrange affiliations with Ontario's mental hospital schools. Organized nursing was prodded to take over responsibility for psychiatric nursing education from the six mental hospital schools. This meeting was groundbreaking for Ontario nurses in that it set the future direction of education for psychiatric nursing. The editor of *The Canadian Nurse* attended the session and published all papers, suggesting that: "Canadian nurses should watch for developments in the scheme for the psychiatric affiliation of student nurses in Ontario".[512]

Ella Smith and Dorothy Riddell, Inspector of Training Schools for the province, believed that the convention was the catalyst for a project which they undertook in the months following. Smith designed a three-month affiliate course which was offered at the Ontario Hospital, Kingston; and Riddell encouraged the superintendents of nurses of seven general hospitals in eastern Ontario to get their students affiliating. There were no psychiatrists involved in planning the project. The main hurdle which had to be overcome for the general hospital superintendents of nursing was how to fit the experience into an already overloaded service-driven curriculum. For this reason, only one of the seven schools was able to offer the experience to all students, with the remaining making it optional. Articles published about this project challenged their colleagues to initiate similar work.[513] Shortly after the Ontario Hospital, New Toronto (Mimico) became an affiliation centre for several more Toronto area schools of nursing.[514]

The Post-War Nursing Crisis at the Ontario Mental Hospitals' Schools

While more general hospital students began experiencing mental hospital affiliations, fewer and fewer students were enrolling at the six mental hospital schools. Enrollment dropped from 155 students in 1944 to just 74 in 1947.[515] A year after he attempted to poach some Manitoba women to Ontario, Dr. J. Phair, Deputy Health Minister, received a letter from Mr. C. Rice-Jones, Manitoba's Civil Service Commissioner, requesting advice on what to do about the shortage of pupil nurses in Manitoba's mental hospital schools. Phair confirmed that Ontario was no further ahead and that there was a shortage of students and nurses throughout Canada and the United States.[516]

In meetings with his medical superintendents, Dr. Phair was forthright, emphasizing that the nursing situation was desperate, and noting that one 1,500 bed institution employed only twenty-nine registered nurses, whereas at the beginning of the war there were 117.[517] The superintendents discussed their perceptions of the causes: high school girls who left school for war-related work were unwilling to return to school, there was a shortage of student accommodation and advertising for students has not worked. They proposed: improved teaching and accommodation facilities, the continued employment of married nurses, training girls from the British Isles or the Maritimes and decreased hospital admissions, especially elderly patients.[518] A few of the superintendents, citing the shortage of nurses as an emergency, suggested starting a two-year course for non-registered mental nurses. Dr. Fletcher recalled training some of his male attendants at the Brockville mental hospital some years earlier, and believed that the

untrained female ward aides who were then being hired could be transformed into student mental nurses.[519] Hamilton's Dr. Senn was not keen, stating:

> We don't have to remind anyone that for many years the mental hospitals in Manitoba and Saskatchewan have been very envious of us because our undergraduate nurses have been able to proceed to the RN degree. It would be a very backward step if we allowed ourselves to be legislated out of existence. I hate to see this. Something has to be done to save the schools.[520]

Dr. Farrar suggested that the basic problem was that two different hospital settings trained two types of nurses–general and mental, and there should only be one type of nurse. He pointed out that psychiatric nursing was increasingly recognized as an essential component of general training.[521] Dr. Stevenson added:

> We have no right to exploit our student nurses, even in our thinking. We should not even consider that we have to run our hospitals largely with the help of student nurses. Leave nursing education to the professional bodies. Our work is to treat sick patients.[522]

Dr. Fletcher disagreed with Stevenson and Farrar and argued that since the general hospitals were still training students, then the mental hospitals could do likewise.[523] Finally Dr. Farrar suggested that a committee of professional nurses ought to study the problem of education for psychiatric nursing in the province.[524] It had been four years since Laura Fitzsimmons surveyed the Ontario mental hospital training schools and recommended that changes were in order. But the war was then in progress and most of the medical superintendents preferred to wait for the expected post-war influx of women to their training schools, than to implement changes. It was clear that Farrar, Stevenson and Senn recognized that the doctors needed some outside help with the critical shortage of students and graduate nurses.

Dr. Montgomery, Director of Mental Hospitals, appointed several well-known nurse leaders to the committee: Nettie Fidler as President represented the RNAO; Dorothy Riddell, Inspector of Training Schools; Edith Dick, Director of Nurse Registration; Hilda Bennett, University of Toronto; Mary MacFarland, Superintendent of Nurses, Toronto General Hospital and Miss Thomas, Superintendent of Nurses, Ontario Hospital, London.[525] Montgomery shared his perception of the crisis, noting that fifteen Ontario Hospitals held 16,000 patients and that patient safety was jeopardized because of the nursing shortage. He advised the nurses:

> A strong group of registered nurses is of the greatest importance to the hospitals. It means modern scientific nursing care for patients. Registered nurses improve the atmosphere of the hospitals...from 1946 to 1947 we have lost 67 registered nurses or 27% of our total. Some superintendents advocate the discontinuation of the training schools altogether. Others want to start a two-year course for mental, non-registered nurses. The thinking is that such a step would be retrograde. But on the whole they are loath to discontinuing the schools before a reasonable supply of registered nurses can be assured from other sources.[526]

Throughout 1947 a tremendous amount of time and effort was devoted to this assignment. Highlights from their report to government included the following:

1. The mental hospital graduate nurse feels isolated from her peers. This will become less as general hospitals open more psychiatric units.
2. Nurses do not want to do non-nursing housekeeping duties which could be assigned to aides. Increase numbers and offer aides same course as in general hospitals.
3. Improved salaries will help attain graduate nurses but money alone cannot solve the shortage.
4. Psychiatric affiliation must be required for registration so that more graduates are prepared to work in psychiatry.
5. Until the affiliation is required, continue Ontario Hospitals' school(s). Applicants are unlikely to increase as the trend is for general nursing schools.
6. Instead of six schools with very small enrollments, establish one central school. Include males in training.
7. In order for more general hospitals to affiliate, the mental hospitals need more residence space and instructors.

8. Include a pediatric affiliation in the Ontario Hospitals' curriculum because some provinces require for reciprocity.
9. Some graduate nurses feel their training is not recognized because of salary inequalities between themselves and untrained attendants. Chief male attendant may receive more compensation than superintendent of nurses.
10. The superintendents of nurses might reasonably be expected to attend meetings of the medical superintendents when nursing education and service are under discussion.[527]

It was then two years since organized nursing in Ontario had committed to getting more general hospital students affiliating to the mental hospitals. However, with this report these nurse leaders were given an opportunity to influence government policy decisions, and they did. Not surprisingly, they did not recommend introducing a new category of mental hospital nurses. Instead, they suggested RNAO certified nurses' aides should assist registered nurses, similar to that which was then occurring in general hospitals.[528] Shortly thereafter Health Minister Russell Kelley announced that such courses would be forthcoming at government institutions.[529] The report made it clear that mental hospital medical superintendents, government and organized nursing needed to work together to get through the crisis at hand. These nurses were aware that even with their low enrollments all the schools could not close until more Ontario students received mental hospital affiliations. The report was optimistic that general hospital psychiatric wards would eventually provide another option for student affiliations. And the nurses even included some subtle comments concerning the long-standing gender and control issues at the Ontario mental hospitals.

It was intriguing that there was almost no discussion of the report by the medical superintendents when it was presented at their fall, 1947 meeting. The minutes indicated that Dr. Montgomery chaired the meeting and that "time does not permit a discussion of

the committee report".[530] However, through to the end of the decade there was attention given it by most of the parties involved. Dr. Montgomery hired Laura Fair as new Supervisor of Nurses to direct service and education at the Ontario Hospitals.[531] This position had been vacant since Esther Rothery left at the beginning of the war. The government finally increased nurses' salaries to match those being paid in Toronto's general hospitals.[532] The one year general hospital affiliation for mental hospital students was moved back to second year from third year. It had been tried in second year in the late-1930's, but early in the war it was switched.[533] As well, a three-month pediatric affiliation was added to the beginning of third year. The government continued to sponsor one year post-graduate courses at the University of Toronto for Ontario Hospital nurses who wished to teach psychiatric nursing at its hospitals.[534]

The Council of Nurse Education initiated work on a new minimum curriculum for the province, and two of its curriculum committee members, Dorothy Riddell and Hilda Bennett, were influential in increasing psychiatric nursing theory from four to forty-five hours.[535] And while clinical experience in psychiatric nursing was listed as a twelve to fourteen week required course, a notation explained this requirement would come into effect in August, 1951.[536] While the government of Ontario, through its Nurse Registration Division, was responsible for nursing education, it was the Council of Nurse Education which advised government. Although the nursing situation at the mental hospitals was critical, the Council was nonetheless unable to insist upon mandatory mental hospital affiliations for all students when the 1949 curriculum was published. The Council was especially concerned about the lack of residence space at the mental hospitals and believed that a few more years of grace were necessary. Further, some

general hospitals continued to over-rely on their students for service and needed time to hire more graduate nurses.[537]

Laura Fair took on the job of organizing affiliations and preparations for the 1951 deadline. She advised the medical superintendents that "the overwhelming scope of the scheme was startling".[538] The physicians desperately wanted more general students affiliating but their hands were tied as far as accommodation was concerned, because the government was responsible for new building at their hospitals. During the war a lack of construction material and labour had slowed all building projects.[539] Fair explored what most general hospitals did when short of accommodation–buying or renting nearby houses–but even this was not usually an option for the mental hospitals because of their rural and often isolated locations.[540] In the meantime, she established small affiliation centres at Ontario Hospitals Brockville, Queen Street, Hamilton and London. By the end of the decade about twenty-five percent of Ontario students received the affiliation.[541] More and more general hospital schools were requesting the mental hospital affiliation and Fair and the Council of Nurse Education ensured that Health Minister Russell Kelley was aware of their predicament.[542]

A description of the Ontario Hospital, Hamilton's affiliation course for general hospital students follows, with a copy of the course outline in appendix F:

> This course in psychiatric nursing is arranged to cover a twelve-week period. In it we attempt to acquaint the student nurse with the various psychiatric problems met within the hospital and community. Throughout we stress the application of the principles of psychiatric nursing to the nursing care of the patient in the general hospital and the public health field. All teaching is directed towards giving the student a full understanding of a sick individual so that her nursing care may become complete. We do not attempt in twelve weeks to make a psychiatric nurse, but rather a better nurse with an awareness of her patients' social, mental and physical problems. Student nurses are on duty 48 hours a week,

> including class (100 hours). Four hours off-duty are given for all statutory holidays. On completion of the course a full report of all experience, together with all ward reports will be sent to the home school.[543]

Government Intervenes in the Mental Hospital Student Nursing Crisis

In an attempt to recruit more students to the six mental hospital schools, Health Minister Russell Kelley convinced his government to increase the monthly allowance from $20.00 to $30.00 (year 1), $20.00 to $25.00 (year 2) and $15.00 to $50.00 (year 3).[544] An extensive advertising campaign was undertaken, targeting rural communities. The minister believed that there were numerous young women in these areas who had been prevented from entering general hospital schools because of the expense.[545] Dr. Senn, Medical Superintendent at the Ontario Hospital, Hamilton, pointed out that it was more productive for his school to advertise in the small papers and not the *Hamilton Spectator* or *Globe and Mail*.[546] Laura Fair designed a brochure and encouraged her superintendents of nurses to give speeches to local high school girls. Their message emphasized that there "would be work for you when you graduate".[547] The mental hospital division also set up a display at the Canadian National Exhibition in Toronto and distributed several thousand copies of the new brochure.[548] At the end of the decade these strategies resulted in a gain of only twenty-five students among the six schools.[549]

Health Minister Russell Kelley asked his staff to consider recruiting males to train at their schools. Deputy Minister Phair advised him that there were eight males enrolled at the Ontario Hospital, Kingston and that he did not believe it was worthwhile to target males. He explained that the Kingston, Whitby and Hamilton schools had trained about twenty-three male registered nurses through the early war years:

> Our experience with male nurses has not been a happy one. The figures waned during the war years. Few men with the required qualifications can be persuaded to enter nursing schools. There is little opportunity for employment outside of our own hospitals and very few remained in the nursing field for any period of time.[550]

The CNA was studying the issue of male nurses and sent this summary to the RNAO Board:

> Only Ontario and Nova Scotia prepare qualified male registered nurses. They are not at the standard of female students. Few of them are employed in nursing. There is confusion in distinguishing male nurses from male attendants. There is an element of both antagonism and acceptance of male nurses by other nurses.[551]

The Post-War Shortage of Nurses in Ontario

Health Minister Russell Kelley spent the post-war years attempting to deal with the shortage of nurses, not only at the mental hospitals but throughout the province.[552] He was perplexed that the apparent increase in the numbers enrolled in general hospital schools could not meet the hospitals' post-war demands for staff, and decided that something needed to change. In a press release to the *Globe and Mail* he wrote:

> I am very much concerned with the apparent inability of the present nurse training program to meet the increased demands for nurses. All factors associated with recruitment and training of nurses need to be studied. An effort should be made to eliminate much of the drudgery out of training. Maybe we should engage more help of a domestic type to give girls who are going to be trained nurses more time to study for the technical work. And possibly the training period should be shortened.[553]

The RNAO developed a nine month nurses' aide certificate course which Kelley embraced and promoted.[554] The minister wrote to Paul Martin, Minister of National Health and Welfare, asking for a continuation of the federal war-time grant to the CNA so that Ontario could continue nurse recruitment strategies. He also enclosed news

clippings for his federal counterpart about Canadian nurse graduates leaving to work in the United States.[555] Minister Martin offered some advice to Kelley:

> This department has been concerned for some time about the nurse shortage. The war jobs competed with nurse recruitment but from 1940 to 1946 there has been a 45% increase in nurses graduating thanks to our $800,000 grant to the CNA. This problem is a complicated one but I believe it depends on providing satisfactory conditions of employment, training and pay rates. In keeping with today's standards of living this vocation needs to be made materially more attractive. Your government can use aides and investigate the curricula of training schools. I am reluctant to continue our grant to the CNA as education is a provincial concern.[556]

Health Minister Kelley's attention to the overall provincial nursing shortage allowed him to keep the shortage of nurses at the mental hospitals in context. As in Manitoba, he learned that the shortage of mental hospital nurses was but a reflection of the provincial nursing shortage and amplified by less than ideal training and working conditions at the mental hospitals.[557] His action around the nurse leaders' report on psychiatric nursing attempted to improve some conditions. For instance, he committed to initiating the RNAO's nine-month nurses' aide certificate course at the provincial hospitals.[558] However, because of financial constraints, his government was unable or unwilling to build more nurses' residences at either mental or general hospital schools.[559] Without more accommodation it was impossible to establish further psychiatric affiliations for the general schools. Nor did Kelley move to centralize the six small mental hospital schools as the nurses' report recommended. However, Kelley was aware that the mental hospital schools, no matter how small they had become since the end of the war, were important symbols for most of his medical superintendents. This was a large and powerful group of psychiatrists, and as Edith Dick, Director of the Nurse Registration Department assessed, they were not yet ready to relinquish control of their schools.[560] Of all the players which

needed to pull together to survive the nursing crisis, the medical superintendents were perceived as the least helpful. Seven years after the nurse leaders' committee submitted their report, Dorothy Riddell noted:

> One of our main recommendations was that the schools should be continued as a source of RNs but one central school should be established. Nothing was done. These doctors do not have the same interest in recommendations from the nurse inspector as do general hospital medical superintendents. Directors of nursing cannot make needed changes without their support.[561]

The ambivalent relationship that many of the Ontario medical superintendents had with nursing was intriguing. They wanted and needed schools and nurses, while at the same time their tight control of all aspects of their hospitals, including nursing education, was a hindrance to mental hospital nursing's development. However, since medical superintendents did not have much status outside their hospitals, they firmly controlled the inside environment. Simmons' research on mental health policy in Ontario found that most of the institutions were run in an authoritarian fashion and in some cases, like fiefdoms. Dr. Fletcher of the Ontario Hospital, Whitby, was said to have been the last of Ontario's "feudal lords".[562] It was perhaps understandable that Dr. Montgomery did not leave time on the agenda for discussion of the nurses' report. He was their director but also a physician, and the report would have been perceived as threatening the authority of his fellow medical superintendents.[563]

The Federal Survey and Ontario Findings

As she had for her survey of mental hospitals in Manitoba and Saskatchewan, Elsie Ogilvie made a point of speaking with Ontario nurses about the status of mental

hospital nursing in that province. Edith Dick, Assistant Director of the Nurse Registration Branch advised Ogilvie:

> Our feeling is that you will in all Ontario mental hospitals find depleted nursing staffs and patient congestion due to delays in construction. We wonder sometimes how the nurses manage. We are hoping that the increase in the general hospital affiliations with the mental hospitals will in time assist the hospitals in attaining a more stable RN staff. The field of psychiatric nursing should have a tremendous appeal to the general hospital graduate who has had an affiliation and introduction to it.[564]

Ogilvie's assessment of the status of nursing at the Ontario mental hospitals was surprisingly positive. She found a well-organized dedicated group of 345 registered nurses, but a tremendous problem with student numbers. She recommended a continuous recruitment program in an attempt to keep the schools operating. Ogilvie was particularly impressed with the increased emphasis being placed on psychiatric nursing by general nurse educators and by the enthusiasm which Ontario nurses displayed.[565] In spite of the medical superintendents' patriarchal control, from 1945 it clearly was organized nursing which was charting the course for psychiatric nursing's future in Ontario.

RNAO Board members became aware that a second psychiatric nurses' association had appeared in Western Canada, this time in Alberta. The registrar of the Alberta Association of Registered Nurses (AARN) explained that her association wanted to "take a stand" but first wanted the RNAO's advice as to what its reaction had been to psychiatric nurses' associations in Ontario.[566] The Board's response to the AARN advised that there was not a separate psychiatric nurses' association in Ontario and that under their Act, graduates of the Saskatchewan program were not eligible to practise in Ontario.[567] Board members believed that "this new western association was not likely to be a problem in Ontario and the matter did not require further discussion".[568] While this

response likely was not helpful to their Alberta colleagues, and was in contrast to the concern expressed by Ella Howard of the University of Toronto just a few months earlier,[569] the Board was apprised of the western provinces' nursing issue.

At the Ontario Hospital, Hamilton, Ogilvie reported:

> 1600 patients (772 male, 828 female) and 34 registered nurses which is a drop of nine in the past two years. The loss of these registered nurses is blamed on a lack of decent accommodation and the distance to the city. There are 19 students and an active nurses' alumni association. There are a large number of elderly bed patients which makes the nursing load heavy. In an attempt to relieve the nurses and students of some housekeeping chores, the number of female ward aides has doubled over one year to 28. There is no training course in place for this group. There is a well-prepared nursing curriculum of 893 hours of lectures and labs over three years. Classes are held during the eight hour day shift and students have one day each week off plus a three week summer vacation. The superintendent of nurses Katherine Turney is in charge of the female wards and the male reception and infirmary wards. The students take their affiliation year at the Toronto General Hospital. Patients received electro-convulsive treatments, insulin shock and a surgeon from Toronto visits to do lobotomies. The nurses' home is old and was the early infirmary. It has large draughty windows and the plumbing is antiquated. There is a smaller residence which was originally the doctors' residence and is more satisfactory. Both Turney and Dr. Senn favoured starting the twelve week affiliate course for Hamilton area general hospital schools. This hospital presents an excellent setting for students but there is a great need for a modern nurses' residence. Hamilton hospitals are now demanding affiliations with this mental hospital. From 1912 to 1947 there have been 321 nurses graduated. Until 1943 the hospital was able to maintain a large staff of graduate nurses and nurses aides were not required.[570]

Ogilvie's report was one of several at the end of the decade which described the need for a new nurses' residence.[571] The lack of construction during the war years was offered as one reason, and further, the provincial government was reluctant to spend money on a residence when patients needed beds.[572]

Memoirs of Some Retired Ontario Hospital, Hamilton Graduates

In contrast to mental hospital nurses in Manitoba and Saskatchewan, some of the retired Ontario Hospital, Hamilton graduates grew up in locations outside of Ontario, specifically in rural Saskatchewan. Hospital records supported this finding. Throughout the decade almost all classes listed two or three graduates from Saskatchewan, but the majority were from towns in Ontario–Dundas, North Bay, Brantford, St. Catharines, Galt, Guelph, Cobourg and St. Thomas. Toronto and Hamilton were listed infrequently.[573] According to the retired nurses who came from Saskatchewan, it was by word of mouth as to how they learned about the training school in Hamilton. For example Annie Smith (Galuska) heard about it from a friend's sister and Irene Wilson (Haverty) said a teacher gave her the information.[574]

As in previous decades most of the retired Hamilton graduates were white Anglo-Saxon Protestants with family names Jarratt, Haverty, Tournay and Campbell. Of the interviewees, only Annie Smith (Galuska) was born to parents of Eastern European heritage. Her parents emigrated from Poland to the prairies a few years before her birth.[575] Hospital documents verified that the majority of 1940's graduates shared a white Anglo-Saxon background.[576]

And like the retired Saskatchewan and Manitoba mental hospital nurses, the Hamilton nurses described their families as either middle or working class. Some experienced severe conditions during the Depression, particularly the Saskatchewan families. For instance Irene Wilson (Haverty) said that her father had come to Saskatchewan from Ireland to homestead but within a few years after the Depression appeared, "the bank foreclosed and then it all blew away".[577] Except for one graduate[578]

the reason why these nurses chose the Ontario Hospital, Hamilton for nurse training was identical to the western interviewees–financial. The idea of being able to obtain a registered nurse diploma and a small monthly allowance, was a wonderful incentive. For example, Annie Smith (Galuska) was employed at the Weyburn Mental Hospital as a nurse-attendant in 1938-39 and when a friend found out about the advantages of the Hamilton school, "we saved our money, resigned from Weyburn and took the train to Hamilton.[579] And Joyce Costley (Tournay) with her Hamilton home near a few general hospital training schools, chose the Ontario Hospital because her father was self-employed and she did not wish to burden him with costs for her education.[580] All of these retired graduates recalled wanting to become registered nurses since childhood but that general hospital training schools were out of the question. Even the costs of having uniforms made did not fit their families' budgets. Joyce Costley, for instance, said she only had to pay for her stockings.[581] As young women none of them ever planned to take her training at a mental hospital. Joyce Costley, for instance, said that while in high school a girlfriend who was already training got her interested.[582]

Similar to the Brandon retired nurses, the Hamilton nurses had families who supported their decisions to train at the mental hospital. It was particularly difficult for the young Saskatchewan women to move so far from home, but as Irene Wilson (Haverty) recalled, "it was a positive thing because I was going to better myself".[583] Annie Smith (Galuska) said "it was like setting out on a three year adventure".[584] During training their visits home were infrequent and neither ever permanently returned.

The retired Hamilton graduates recalled their probationary six month period of many classes, studying and some work on the wards. Caps were received at the

completion of probation. Like most student nurses, their uniforms were the standard blue with white bibs and aprons and black stockings and shoes.[585] They had warm memories of Katherine Turney, Superintendent of Nurses. She was "professional and strict but had a heart of gold".[586] Irene Wilson (Haverty) was affiliating in Toronto and things got so bad for her one day that she took the train home to Hamilton and told Turney that she was quitting. Turney would have none of it and the next day Irene was back at St. Michael's.[587] Turney did some of the teaching along with Priscilla Dodd, full-time instructor. Dorothy Mulder (Campbell) said that having nurse instructors lecturing, instead of physicians as had been her experience in North Battleford, was a big difference between the two schools. The physicians still taught some classes but this decreased during the decade. Skills were taught and practised in the demonstration room before the students were allowed to use them with patients.[588]

The students started with twelve-hour shifts but by the end of the war eight hour shifts were introduced. Classes were held during ward shifts and they had either Saturday or Sunday off each week. They reported long, heavy days and studying together during their free time.[589] Dorothy Mulder (Campbell) recalled the post-war nursing shortage and says it was almost unbearable. She became ill with tuberculosis in 1946 and blamed it on being overworked and tired.[590]

The retired Hamilton graduates had vivid memories of learning to care for electro-convulsive treatment patients. Dorothy Mulder (Campbell) recalled "a whole room with electric shock procedures going on. The terror that those patients went through before they had the shock was unforgettable. There was no anaesthetic, no muscle relaxant, the grand mal seizure was dreadful".[591] Annie Smith (Galuska) said that four

student nurses had to hold patients down during the seizure so that they would not fall off the stretcher and hurt themselves.[592] Joyce Costley (Tournay) said "it was painful to watch".[593] Leucotomies were done less frequently and the students participated in the surgical procedure and the retraining program. Annie Smith (Galuska) described how a famous Toronto General Hospital neurosurgeon, Dr. K. McKenzie, "did the sickest patients, the ones who had been in the hospital for years and who had not improved. It was their last resort. It was really just two holes and they healed quickly. But for us students it was then quite a chore to rebuild their memories and retrain them."[594] Dorothy Mulder (Campbell) remembered that the patients who had leucotomies were "easier to manage and less violent. They were docile but their spirit was gone. They would answer yes and no...just shells of their former selves".[595] However, a highlight of Mulder's training was giving some of the first penicillin used at the hospital to a young war veteran with syphilis. Penicillin quickly took over from heat cabinets as the treatment of choice to prevent general paresis of the insane caused by syphilis.[596]

The Hamilton nurses verified that the one-to-one relationship with patients was not taught to them during their training and that it was not possible to have meaningful discussions with most patients until the next decade, when a new anti-psychotic medication was used at the hospital. In spite of this inability to relate, they believed that their most important role was "being there" for patients. There was no emphasis placed on talking to patients' families and they rarely saw families visiting.[597]

These retired graduates were less caught up with stories of cleaning than were their Brandon counterparts. They said they had to clean and directed patients to clean the

wards, but it definitely was not an important student role. The ward aides also assisted with cleaning chores.[598]

In contrast to the nurse leaders' concerns, and perhaps related to their families' financial status, not one of the retired Hamilton graduates had anything negative to say about their residence. Irene Wilson (Haverty) arrived from Saskatchewan at the end of the Depression and recalled the beautiful hospital grounds with acres of green grass and orchards, and how happy she was with her new home. She explained that the former superintendent's home had been converted to a seventeen bed student residence and it became their home.[599] Dorothy Mulder (Campbell) said the residence was "like heaven"[600] and Annie Smith (Galuska) said residence life "helped me, a naïve girl from Saskatchewan to grow up and experience life. I learned lots of my social skills there".[601] Even Joyce Costley (Tournay) from Hamilton claimed residence life was one of her happiest life experiences: "We did everything together. My roommate and I became like sisters and we still communicate."[602] They recalled 10pm curfews and sneaking in and out. Most of their time off was spent on the hospital grounds, participating in activities such as tennis, curling and bowling. Trips to the nearby Lookout Inn for something to eat were a common diversion.[603]

All of the retired Hamilton graduates affiliated for one year, in second year or third year, to Toronto area hospitals. Because Irene Wilson (Haverty) was Roman Catholic, she was sent to St. Michael's Hospital, a hospital administered by the Roman Catholic Church. She was the only one of these graduates who reported that the general affiliation was a bad experience.[604] She reported that the nuns were abusive and controlled the student nurses' every move. She said she was treated like a slave, and even

assigned to wash dishes in the hospital kitchen. She almost quit training the day a nun shoved and poked at her in the operating room over a perceived insignificant error. Wilson reflected that while the training at the mental hospital was not easy, at least she had been treated in a humane manner.[605] Annie Smith (Galuska) remembered feeling overwhelmed when she arrived at the Toronto General Hospital for her affiliation. Even just finding her way through the tunnels was a daunting task. She and others who trained at this hospital said they were accepted and treated kindly. Smith said this affiliation sparked a desire to go on for further education in nursing.[606] And as some of the Brandon nurses mentioned, nursing male patients during their affiliation was a new experience that created undue anxiety.[607]

These Ontario Hospital, Hamilton retired graduates spoke with a great fondness for their former school. Some were still involved with the alumni association and were in contact with former classmates. Irene Wilson (Haverty) and Annie Smith (Galuska) viewed graduating with their RN diplomas as an important personal accomplishment. Wilson said she felt blessed to have her nursing career.[608] Smith recalled her Polish-born parents' desire for her to be as well educated as any "man of the day".[609] Within a few years of graduation she was enrolled at the University of Toronto's School of Nursing for the Ontario government-sponsored post-graduate clinical supervision course.[610] Not long into her career she became the supervisor of nursing at her alma mater when she succeeded Turney. Smith told of her later administrative struggle to bring the male service under her management, the power of the chief male attendant and the displeasure of the male attendants.[611] Wilson and Mulder worked in psychiatry until they had their first babies and then "retired" from nursing for several years. Both eventually returned to

psychiatric nursing in general duty positions.[612] Joyce Costley worked for a few years at the hospital and then spent her career in geriatric nursing, using many of her psychiatric nursing skills.[613]

Summary of the Ontario Case

Several key decisions made by organized nursing and the Ontario government following World War II determined psychiatric nursing's place and future within general nursing: an RNAO convention devoted to psychiatric nursing, a new curriculum which included a psychiatric course and affiliations, a government plan to offer nursing assistant courses at its mental hospitals and the ongoing funding of nurse instructor courses for mental hospital training. Although some medical superintendents wanted to solve the severe mental hospital nursing shortage through the creation of a two-year non-registered mental nursing course, a coalition of nurse leaders negated that option. At the end of the decade six mental hospital schools remained, albeit with small enrollments, and twelve-week affiliations for general hospital students were slowly becoming the norm. The demand for these affiliations was tempered only by the government's lack of resources to build new student residences at its mental hospitals. While the medical superintendents retained their traditional control of education and practise at the Ontario Hospitals, strong nursing leadership led the movement to psychiatric affiliations.

Conclusion

This chapter has shown that during the 1940's, the successes or failures of organized nursing, medical psychiatry and governments in their quest to control

education for psychiatric nursing resulted in the development of different models of education across three provinces. Saskatchewan's new CCF Government was committed to mental hospital reform and created a well-funded British-style apprenticeship training program using an abundant attendant workforce, and further, legislated a new psychiatric nursing profession for these workers. The traditional authority given to the province's commissioner of mental services and its medical superintendents was retained. The Manitoba government's long-standing weak administrative role with its training schools allowed the superintendents free rein, resulting in an inconsistent approach to training. Government's contribution was to offer improved compensation as an incentive to student enrollment. The Ontario government, on the other hand, was responsible for nursing education both general and mental; and sensing that its medical superintendents needed assistance with the drop in enrollment, it called on a committee of nurse leaders to advise government. While the medical superintendents were not yet ready to relinquish control over their schools, government used most of the nurse leaders' recommendations in its plans. Key was the decision to implement the RNAO's nine-month nursing assistant course at its mental hospitals instead of a separate mental nursing program. Missing from the Ontario plan was the political will and financial commitment to increase student accommodations at its training schools.

Registered nurses historically had been shut out of mental hospital employment in Saskatchewan; and in spite of a decade-long struggle by Kathleen Ellis to obtain mental hospital affiliations for general students, the situation remained unchanged. Once the government chose to upgrade its attendant training program, there was no need for general students to affiliate and general students became irrelevant to the mental hospital

situation. In spite of Ellis' leadership, a unique political climate and a powerful psychiatrist resulted in only ten percent of the province's students receiving a psychiatric affiliation, all at one small urban facility.

Organized nursing in Manitoba, like government, displayed little leadership around the shortage of mental hospital nurses. That the combined program and reciprocal affiliations occurred was due to the leadership of a few superintendents of nurses and instructors. The MARN endorsed these arrangements but it did not commit general students to a required psychiatric affiliation. Such experiences remained optional and meant that only ten percent of Manitoba students received this affiliation.

In contrast to nursing in these two western provinces, organized nursing in Ontario had a long-standing formal relationship with mental hospital nurse training. While their relationship was not always smooth, it was not a surprise that the RNAO leadership publicly resolved to take more responsibility for helping with the mental hospital shortage vis-à-vis increased affiliations. This commitment was aided by nurse leaders who advised government that such affiliations could no longer be optional, and by the consequent new curriculum which set a deadline for the required psychiatric affiliation. These leaders refused to support the option for initiating a separate mental nursing course because in Ontario, registered nurses traditionally provided psychiatric nursing care, at least to female mental hospital patients. Mandatory psychiatric affiliations for all general hospital student nurses would continue that tradition but this was dependent upon increased student accommodation at the mental hospitals. At the close of the decade twenty-five percent of Ontario students received the affiliation, and

organized nursing and the Ontario government had until 1951 to resolve the shortage of residence space.

There were similarities between the Saskatchewan findings and Nolan's description of the relationship between British mental and general nursing during the 1940's.[614] Mental hospital nurse training was controlled by medical psychiatry which offered a program through its professional association, the Royal Medico-Psychological Association (RMPA). The Royal College of Nursing (RCN) refused to recognize these trainees as nurses because they lacked general nurse training, but they were allowed to register under the General Nursing Council (GNC) on a separate register, provided they passed the GNC examination in mental nursing. However, the GNC asserted that this psychiatrist-run apprenticeship training program was outdated and not focused on nursing, and initiated plans to take over mental nursing education from the doctors. The mental hospital medical superintendents resented nursing leaders' interference and there was a lengthy struggle for the control of mental nursing education.[615] Nolan pointed out that registered nurses could specialize in psychiatric nursing if they took a post-graduate course offered by the GNC, and that such nurses had more status than the mental hospital trained nurses by virtue of their general training and RCN membership.[616] Unlike in Saskatchewan, the British mental nurses did not have a professional association, but many were active in the National Asylum Workers' Union.[617]

The Ontario findings mostly echoed Church's description of what occurred in the relationship between organized nursing and American mental hospitals during the 1940's.[618] As she had done in Ontario, Laura Fitzsimmons conducted the same American Psychiatric Association (APA) survey of thirty-two state mental hospital training schools

and although the American and Canadian findings were the same, the response by American psychiatrists was in contrast to that of their Ontario colleagues. Her finding that the shortage of students was not just war-related and her recommendations for change were accepted.[619] And while the Ontario psychiatrists got stuck on her recommendation to centralize the nursing service under the superintendent of nurses, their American colleagues passed a resolution that this recommendation be accepted as an APA policy.[620] Fitzsimmons' work for the APA triggered a new era of collaboration between organized nursing and medical psychiatry around psychiatric nursing education. Church reported that for the first time nurse educators and psychiatrists worked together on interdisciplinary committees. The goal was to increase the number of registered nurses working at mental hospitals, and as the nurses increased mental hospital affiliations, the doctors lessened their hold on education for psychiatric nursing at their institutions.[621] In Ontario, Fitzsimmons' words were an inspiration to nurses attending the 1945 RNAO annual meeting–a commitment to more affiliations was made. But she did not stimulate any medical psychiatry-nursing collaborative efforts.

As it did in Canada, World War II created a new public and health professional interest in mental health issues in the United States. The federal government initiated numerous mental health-related initiatives. As a result of a recommendation by Fitzsimmons, federal funds were allocated to the thirty-two mental hospital schools to strengthen their programs and promote affiliations.[622] Church found that the largest federal impact on the mental hospitals was an indirect one. Thousands of American student nurses were recruited through the federally-sponsored Cadet Nurse Corps Program and almost all of these students received a psychiatric affiliation so that they

were prepared to help military staff and veterans with any mental health problems.[623] The psychiatric affiliation became known as a "credible requirement instead of an interesting option" and by the end of the decade about seventy-five percent of all American nursing programs offered this affiliation to its students.[624] That general nursing's interest in psychiatric nursing was at an all-time high was attributed to some of Fitzsimmons' work. Church suggested that her leadership was critical to the development of the American psychiatric nursing discipline.[625]

While their provincial governments and organized nursing varied considerably in the approaches taken to train and staff the mental hospitals, the nurses who trained and worked at the North Battleford, Brandon and Hamilton mental hospitals in the 1940's shared more similarities than differences. They were predominantly white Anglo-Saxon Canadian-born women who grew up in rural areas not far from the provincial mental hospitals. Surprisingly, none reported mothers, sisters or other family members who were either registered or mental nurses. The majority had always wanted to become registered nurses but their working-class parents could not afford even the minimal costs around general hospital training schools. Mental hospital schools, with their monthly allowances or wages, were the viable alternative to further education and becoming a nurse. McPherson's study of general hospital-trained Canadian nurses also reported an almost exclusive white Anglo-Saxon female population until after World War II.[626] And while her findings revealed that a large number of women in each class were from rural areas, urban students were also represented.[627] It might have been that urban women did not consider mental hospital training because they had more wartime work-related options available than rural women. A significant finding was the difference in family class

backgrounds between the mental hospital nurses and the general hospital nurses in McPherson's study. While McPherson dispelled the myth that all general hospital nurses were from middle class backgrounds, she nevertheless found a mix of middle and working class family backgrounds.[628] Middle class students were conspicuously absent at mental hospital training schools.

Students at the three mental hospitals experienced difficult training conditions, especially noting large numbers of patients to care for and not enough trained nurses to guide them. They had surprisingly similar recollections of feeding, bathing and cleaning and identical experiences with medical treatments, for example electro-convulsive therapy. Even their concerns for their patients' frightening seizures did not vary. Their workloads were heavy, especially for the Manitoba and Ontario students who also had to meet the curricular requirements of the provincial nurses' associations. In spite of the horrendous conditions, the good memories of their training outweighed the bad, and most revolved around activities outside of hospital work and a strong sense of belonging to the larger hospital community. As at general hospital schools, residence life was the central piece in students' lives at Hamilton and Brandon.[629] That was their world for at least three years, and as such, they were unaware of the struggles taking place for control of their education.

Almost all of the participants reported productive careers spent in nursing, either psychiatric or general, with those who trained at North Battleford remaining at this facility. Their careers commenced during the height of the post-war mental hospital nursing shortage and it was only through personal choice that some temporarily left nursing to raise families. As it had done for their general hospital-trained counterparts,

the post-war nursing shortage insured continued employment and career-building, something not generally experienced by other women of the day.[630]

While Church did not examine the American mental hospital students' perspectives, some of the interviewees' stories are consistent with Nolan's British findings. His female participants reported a desire to be "nurses", and indicated that it did not matter to them that they were training to be mental as opposed to general nurses. That they received a salary was an incentive and some perceived their training as a job more than an education.[631] While the British interviewees perceived a much more rigid and disciplined hospital environment, their custodial patient care activities matched those of the Canadian participants. Despite the unfavourable hospital conditions, the British participants also enjoyed being a part of the family-like hospital community.[632] Like their Canadian sisters, the British retired nurses looked back on long mental nursing careers; and similar to the Saskatchewan interviewees, they spent them at the home hospital.[633]

The main difference between the British and Canadian findings centered on education. Nolan's participants perceived their nurse training as irrelevant to their actual work on the wards. They told of attending one optional weekly lecture and of spending all their training working on just one ward.[634] The Saskatchewan participants reported minimal class time but all the Canadian interviewees valued their education.

While education for psychiatric nursing in Britain and the United States during the 1940's shared few similarities, the educational programs within each country were nonetheless uniform. The same could not be said for psychiatric nursing education programs across the three Canadian provinces. A new program in Saskatchewan was modeled on the psychiatry-driven separate British mental nursing program; and except

for their designation, the two programs shared similar characteristics. Ontario and the United States both offered the combined mental and general nursing diploma programs, but these were projected to disappear with the nurse-lead expansion of psychiatric affiliations for general students. Concurrently, medical psychiatry's monopoly of education for psychiatric nursing was weakening. Manitoba had three training schools and three different educational models and there was no province-wide plan on the horizon. As the decade closed education for psychiatric nursing was not developing as one seamless model across the geographical boundaries of these three neighbouring provinces. As the next chapter will show, these provincial variations set the stage for a critical battle for control of education for psychiatric nursing, and for the first time internal provincial struggles moved onto the national scene.

Notes

1. Terry Copps, "The Development of Neuropsychiatry in the Canadian Army (Overseas) 1939-1943", in *Canadian Health Care and the State. A Century of Evolution* ed. D. Naylor (Montreal : McGill-Queen's University Press, 1992), 67-84.
2. Charles Roberts, "Development of Mental Health Services and Psychiatry in Canada: Lessons from the Past: Problems of the Present and the Future", *Canadian Journal of Psychiatry* (May 1989):291-98.
3. Copps, 71-73. Except for Copps' article there was no other documentation concerning the home hospitals of the nurses who staffed this psychiatric hospital. It is not known if any nurses from other Ontario provincial mental hospitals nursed at Basingstoke per se, but many served as Nursing Sisters. See AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Letter from Dr. McGhie to L. Fitzsimmons, May 23, 1944, McGhie advised that he had recently lost nurses from the Ontario Hospitals to the Armed Forces.
4. Copps, 67-84.
5. Roberts, 291-92.
6. PAM, off-site, H-16-19-1, Temp. Box 18, Box 3, Health and Welfare Minister's Office Files, Psychiatry, General, 1944-49, Letter to Ivan Schultz (and all provincial health ministers) from Dr. Hincks re-visits, Jan. 15, 1946.
7. Roberts, 291-93.
8. PAM, off-site, H-16-19-1, Temp. Box 18, Box 3, Health and Welfare Minister's Office Files, Psychiatry, General, 1944-49, Letter to Ivan Schultz (and all provincial health ministers) from Dr. James, McGill University, June 15, 1945.
9. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 1, The Maritimes", *Liberty* (Jan. 25 1947):8,9,34-36.
10. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 2, The West", *Liberty* (Feb. 8 1947):8,9,38-41.
11. Ibid., 9,38.
12. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 3, Ontario and Quebec", *Liberty* (Feb. 25 1947):8,9,34-38.
13. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 4, Thousands Could be Cured", *Liberty* (March 8 1947):8,9,46-49.
14. PAM, off-site, H-16-19-1, Health and Welfare Minister's Office Files, Psychiatry, General, 1944-49, Copy of *Winnipeg Free Press* article "Author Challenges Minister of Health", May 12, 1947. Attached to article were undated pages from *Hansard*.
15. SAB, R326,28 (2-11), "Conditions in Mental Hospitals Admittedly Bad but Alleviation Efforts Made, Says McKerracher", *Regina-Leader Post*, June 6, 1947.
16. NAC, Government Documents, House of Commons Debates, Vol. VI, 1948,

6178.
17. Roberts, 293-95.
18. AO, GR10-107-0-165, Container 22, File: Nurses, General, 18-7-3, 1938, Letter from Dr. MacNeill to Dr. McGhie, July 18, 1938.
19. SAB, PH3, File 9A, List of employees and salaries sent to Dr. Campbell from Dr. MacNeill, Oct 1, 1937.
20. SAB, PH3, File 9A, Letter to Dr. MacNeill from Dr. A. Campbell, Dec 6, 1937.
21. SAB, PH3, File 9A, Letter to Dr. A. Campbell from Dr. J. MacNeill, Dec 30, 1937.
22. SAB, R-398, Pamphlet File, Hincks Commission Report, 1930, Miss Hazel Jacques noted to have dietician degree. At other times she was said to be an occupational therapist because she managed that department and sometimes she told people she was a school teacher. She had been with MacNeill from the day the North Battleford institution opened in 1914.
23. George Weir, *Survey of Nursing Education in Canada* (Toronto: MacMillan Co., 1932), 301.
24. SAB, PH3, A9, 1932-35, Letter from Dr. MacNeill to Dr. A. Campbell, April 2, 1932. MacNeill's philosophy about psychiatry allowed him more control of what went on inside the mental hospitals. Registered nurses from the outside might have challenged his authority. Attendants did not.
25. SAB, R398, Pamphlet File, Hincks Commission Report, 1930. Drs. Hincks and MacNeill were good friends and so Hincks was reluctant to criticize his administration of the Saskatchewan mental hospitals. It was noteworthy that these recommendations were made.
26. SAB, SPH3, File 4B, Middleton, 1933-4, Letter to Deputy Minister of Public Health Dr. F. Middleton from Dr. A. Campbell, Weyburn regarding lectures and requested a copy of new diploma, Feb 16, 1933.
27. Donald McKerracher, "A New Program in the Training and Employment of Ward Personnel", *American Journal of Psychiatry* (Oct 1949):259-264.
28. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. Vowles wrote that some attendants were not permitted to take more lectures and some chose not to.
29. SAB, PS, File A17, Public Service, Mental Hospital Prerequisites, Letter to P. Shelton, Public Service Commission Chairman from Dr. MacNeill re-male staff, Dec 22, 1930.
30. See for example WGH Alumnae Archives, Journal Collection, George Stevenson, "Ward Personnel in Mental Hospitals", *The Canadian Nurse* (Jan 1935):5-10. Paper also presented to the American Psychiatric Assoc. 1934 meeting which had Canadian attendees.
31. AO, RG10-107-0-165, Container 22, File: Nurses, General, 18-7-3, Letter from Dr. MacNeill, Commissioner of Mental Services to Dr. McGhie, Deputy Minister of Health, Ontario re-general hospital affiliations, July 18, 1938.
32. U of S Archives, College of Nursing, article from *Regina Leader Post,* "Nursing Pioneer Dies", March 20, 1968.
33. U of S Archives, College of Nursing, Report to the Committee on Policies Affecting Schools for Nurses, SRNA, March 3, 1938, from K.W. Ellis. Ellis visited all

general schools and flagged the problem of a lack of registered nurses and student nurses in psychiatric nursing. Her report described the affiliation as essential in nursing education–no doubt she heard this message at Columbia University.

34. SAB, PH3, File 9A, Dr. MacNeill sent a letter to Dr. Campbell and told him that there was no money to hire registered nurses to help do the insulin treatments, Dec. 10, 1937. This came after the two argued about Campbell's need for RNs and some had applied for this work. MacNeill did everything in his power to prevent RNs from getting hired.

35. SAB, SRNA, R-993, 43F (4.2-9), Registrar, Report to the President and Council, June 18, 1938 of visit to the mental hospital at North Battleford May 15-18. The purpose was to ascertain whether conditions were favourable for affiliation. This visit took place within a few months of identifying the gap so she was moving quickly.

36. Marguerite Robinson, *The First Fifty Years* (Regina:SRNA, 1967), 57.

37. SAB, R-398, Pamphlet File, Hincks Commission Report, 1930; Harley Dickinson, *The Two Pyschiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 25-45; D. Kildaw, *A History of the Saskatchewan Hospital, North Battleford* (Saskatoon: Univeristy of Saskatchewan, 1991). Originally the hospital was called the Battleford and the name was interchanged.

38. SAB, R-999,22 (172 D3), Report of Commission of Inquiry into the Administration of the Provincial Mental Hospital, North Battleford, April 8, 1946. Commissioners Shumiatcher, M., Bethell, W., Williams, D.

39. SAB, R-398, Pamphlet File, Hincks Commission Report, 1930. Provincial governments were often at a loss as to what to do about their mental hospitals and so allowed the medical superintendents a great deal of authority with little accountability. See Harvey Simmons, *Unbalanced: Mental Health Policy in Ontario, 1930-1989* (Toronto: Wall and Thompson, 1990), 8-9.

40. RPNAS, North Battleford Archives, Ken Johnstone, "Mental Hospital. Despite Overcrowding, North Battleford Sets Standard of Treatment", *The Standard* (Aug 24 1946):10-17.

41. SAB, SRNA, R-993, 43F (4.2-9), Registrar, Report to the President and Council, June 18, 1938 of visit to North Battleford May 15-18. Ellis sent the CNA's Proposed Curriculum (1936) because the SRNA council wanted all schools in the province to use it as their guide.

42. SAB, SRNA, R-1271-51, 1933-39, Council Minutes, meeting June 18, 1938.

43. SAB, SRNA, R-993, 43F (4.2-9), Report of a Study of Plans for Affiliation with Mental Hospitals, prepared by K. Ellis, Registrar and Miss Cleaver, Oct 15, 1938. The info received from Ontario included Esther Rothery's work to increase the number of general hospital schools affiliating to mental hospitals.

44. Ibid. The two-year general hospital affiliation was established for Ponoka by Dr. Baragar and Catherine Lynch formerly of Brandon.

45. SAB, SRNA, R-1271-51, 1933-39, Council Minutes, meeting Oct 15, 1938.

46. Just a few years earlier, the AARN's executive council expressed concern that a school had been initiated (1932) at the Ponoka Mental Hospital. The University of Alberta Senate approved the plan even though AARN standards were not met at Ponoka. See Janet Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta, 1895-1996*

(Vancouver, UBC/UofA Press, 1998), 220. For the Ontario situation, see CNA Archives, Journal Collection, Julia Stewart, "The Inception and Development of the Graduate Nurses Association, Ontario, 1904-1926, *The Canadian Nurse* (Feb. 1928):64-71. The RNAO was represented on the Council of Nurse Education, an advisory committee to government.

47. AO, RG10-107-0-165, Container 22, File: Nurses, General 18-7-3, Letter to Dr. J. MacNeill from Dr. McGhie, July 25, 1938.

48. WGH Alumnae Archives, Journal Collection, Nettie Fidler, "Psychiatric Nursing", *The Canadian Nurse* (Nov. 1933): 571-578.

49. AO, RG10-107-0-165, Container 22, File: Nurses, General, 18-7-3, Letter to Dr. McGhie from Dr. MacNeill, Aug 3, 1938.

50. AO, RG10-107-0-165, Container 22, File: Nurses, General, 18-7-3, Letter to Dr. MacNeill from Dr. McGhie, Aug 8, 1938. McGhie's note re-25 years prior was when the Ontario medical superintendents established their first schools (1909). The fact that in Ontario attendants did not ever train to become nurses was a major difference between that province and mental hospital training in western Canada.

51. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Miss Jacques, Dec 5, 1938. Some of this letter's assertive tone was most likely rooted in Dr. McGhie's advice to MacNeill.

52. SAB, R-349, Kahan Papers, William Vowles memoires "For the Archives", 1964. See also Peter Nolan, "Psychiatric Nursing, Past and Present: The Nurses Viewpoint" (Ph.D. diss., University of Bath, UK, 1989).

53. SAB, SRNA, R-993, 43F (4.2-9), Letter to H. Jacques from K. Ellis, Registrar, Dec 29, 1938. Ellis was wise to reinforce that the recommendation for a 2 or 3 month affiliation came from the CNCMH which had developed the psychiatric nursing component of the CNA's Proposed Curriculum.

54. SAB, SRNA, R-12-71-51, 1933-39, Council Minutes, Jan 28, 1939. No reason was given for MacNeill's absence from the SRNA council meeting. Perhaps he was sending a message by his absence.

55. SAB, SRNA, R-993, 43F (4.2-9), Letter to Premier Douglas from K. Ellis, Sept 25, 1944. Ellis advised the new Premier of the work done by the SRNA in 1938 to Jan 1939. There was nothing more documented on this topic for the length of the war.

56. SAB, PH Serials, Annual Report, Department of Public Health, 1944.

57. SAB, R97, North Battleford Mental Hospital, File 4B2, Memo from Dr. Davison, Deputy to Hon. J. Uhrich outlined staff numbers, Dec. 14, 1942.

58. SAB, R97, North Battleford Mental Hospital, File 4B2, Letter to Dept. of Pensions, Ottawa from Dr. Davison, Deputy Minister of Public Health, Nov. 18, 1940.

59. SAB, R97, North Battleford Mental Hospital, File 4B2, Letter to Dr. Agnew, Canadian Medical Association from Dr. Davison, Deputy Minister of Public Health, Feb. 27, 1943.

60. SAB, SRNA, R1271, File 52, Council Minutes, 1940-1943, Sept 18, 1942 meeting focused on Ellis' role with the CNA and what the federal grant meant for the SRNA.

61. Health Survey Committee, *Saskatchewan Health Survey Report: Health Programs and Personnel* (Regina: Saskatchewan Government, 1951), 106-115. This nursing survey showed the immediate post-war years were the worst for the shortage.

62. Dickinson, 72.
63. Ibid., 82-86. The UCSC membership included civil servants in all occupations.
64. SAB, R-999, 22 (172 D3), Report of Commission of Inquiry into the Administration of the Provincial Mental Hospital, North Battleford, April 8, 1946. Commissioners Shumiatcher, M., Bethell, W., Williams, D.
65. SAB, SRNA, R-993, 43F (4.2-9), Registrar, Report to the President and Council, June 18, 1938.
66. Dickinson, 72-82.
67. SAB, 251, RC (M13), Henry Sigerist, *Saskatchewan Health Services Survey Commission* (Regina: King's Printer, 1944).
68. Ibid., 7-8.
69. SAB, R-326, 28 (2-11), Newspaper article "Bill Plans Treatment for Mental Diseases", *Regina-Leader Post*, Oct. 2, 1944. Sigerist was interviewed about the legislation and free mental hospital care.
70. SAB, 251, RC (M13), Henry Sigerist, *Saskatchewan Health Services Survey Commission* (Regina: King's Printer, 1944), 11-12.
71 Charles Roland, *Clarence Hincks, Mental Health Crusader* (Toronto: Dundurn Press, 1990), 56-59.
72. SAB, HSPC, 28 (2-11), Clarence Hincks, *Mental Hygiene Survey of Saskatchewan* (Regina: King's Printer, 1945).
73. See for example David MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928", *Canadian Bulletin of Medical History* (Summer 1987): 7-23. Perhaps Hincks' promotion of MacNeill's work was an example of the physicians' "old boys club".
74. Roland, 56-59.
75. SAB, HSPC, 28 (2-11), Clarence Hincks, *Mental Hygiene Survey of Saskatchewan* (Regina: King's Printer, 1945).
76. SAB, R-11-14-19, 1944-52, Letter to Premier T.C. Douglas from Dr. G. Stevenson, Oct 13, 1944. The Premier and Stevenson first met at a Saskatchewan Medical Association meeting and Douglas asked for his assistance. Stevenson surveyed the other western provinces and his report and letter were similar. See AHCPMH, Board of Directors' Meetings, 1943-9, Dec 1, 1944, Stevenson report.
77. SAB, R-326, 110 (6-1-2) A, Letter to K. Ellis from Dr. M. Sheps, Secretary of Health Services Planning Committee, Nov 15, 1944. Douglas put Sheps in charge of negotiations with Ellis. Dr. Sheps told Ellis the Premier was away and wanted to get something going.
78. SAB, SRNA, R-993, 43F (42-9), Letter to Douglas from K. Ellis, Sept 25, 1944. Her letter was also an attempt to let Douglas know that the SRNA was interested in the nursing care of the province's mentally ill patients.
79. Ibid. Also see SAB, SRNA, R-993, 43F (4.2-9), Letter to T. C. Douglas from K. Ellis, Oct 21, 1944. It was clear that she was more enthusiastic about general to mental hospital affiliations than reciprocal arrangements. Her priority was the educational aspect.
80. SAB, R-11, 14-31, Letter to K. Ellis from Premier Douglas, Oct 12, 1944. It was clear that Douglas wanted to work with the SRNA but he wanted something from the association quickly.
81. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Matilda Diederichs,

Oct 23, 1944. At that point the Premier wanted to co-operate with the SRNA in order to get mental hospital student nurses affiliating to general hospitals.
82. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Margaret Street, Executive Secretary, MARN, Feb 7, 1945. Street attached the new four-year curriculum offered by the two Manitoba hospitals since 1943. It is not known why it took four months to obtain the Manitoba information.
83. SAB, SRNA, R-993, 43F (4.2-9), Letter to Premier Douglas from K. Ellis, Oct 25, 1944. Her letter stipulated that these would need to be the basis for further discussion with his office. This was partly due to the rapid response and Ellis wanted the ability to revise the document.
84. SAB, SRNA, R-993, 43F (4.2-9), Letter to Miss Ruth McGill, Barrister, Regina from K. Ellis, SRNA, Oct 24, 1944.
85. SAB, SRNA, R-993, 43F (4.2-9), Letter to T.C. Douglas from K. Ellis, Oct 25, 1944.There was some concern about mental hospital students going to general hospitals.
86. SAB, R-326, 110 (6-1-2) A, Letter to K. Ellis from Dr. M. Sheps, Secretary, HSPC, June 27, 1945.
87. Duane Mombourquette, "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan, 1944-1964" (Masters thesis, University of Regina, 1990).
88. SAB, R-326, 110 (6-1-2) A, Letter to K. Ellis from Dr. M. Sheps, Nov 15, 1944. Sheps and Ellis were discussing plans for preparing nurse-midwives.
89. SAB, HSPC, 67A (4-2-3), Memo re-advanced course in obstetrics for public health nurses, Nov 1944.
90. SAB, R-33.1, 826 (35-14) A, Letter from J. Corman, Attorney General, Saskatchewan to the Premier and all Ministers, re-Proposed Bill regulating the professions in this province, Jan 2, 1947.
91. SAB, R-11, 14-31, Letter to Premier Douglas from K. Ellis, SRNA, Dec 13, 1946.
92. Mombourquette, 78.
93. SAB, R-11, 14-31, Telegram to Premier Douglas from K. Ellis, March 15, 1946.
94. SAB, R-11, 14-31, Memo to T.C. Douglas from Dr. M. Sheps, March 15, 1946.
95. SAB, R-11, 14-31, Telegram to K. Ellis from Premier Douglas, March 20, 1946.
96. SAB, R-11, 14-31, Letter to Premier Douglas from K. Ellis, March 20, 1946.
97. Ellis kept detailed records of her meetings with government and there was nothing further discussed re-psychiatric nursing from June 1945 to Dec. 1946. Also see Mombourquette.
98. SAB, R-11-14-19, 1944-52, "Saskatchewan Shows the Way", *Toronto Star, Weekly,* June 26, 1952; Editor, "News and Notes", *Saskatchewan Psychiatric Services Journal* (1955):61-62. McKerracher went by both Donald and Griff.
99. SAB, R-11, 14-37, Memo to Dr. McKerracher from T.J. Bentley, Minister of Public Health re-one of the best psychiatric services anywhere, Nov 28, 1951; SAB, R-11-14-19, 1944-52, "Saskatchewan Shows the Way", *Toronto Star, Weekly*, June 26, 1952; PAM, H16-19-1, Health and Welfare Minister's Office Files, 1950-57, Letter to Deputy Minister of Health, Manitoba from Mr. Roth, Deputy Minister of Health, Saskatchewan Feb 24, 1954.
100. SAB, R-11-14-19, 1944-52, Memo to T.C. Douglas from Dr. C. Hames, Deputy

Minister Public Health re-attached minutes, May 7, 1947. Hames was relieved that McKerracher was making progress with a training program.
101. SAB, R-11-14-37, Dr. Karl Menninger, "Canada Trip", *TPR* (Oct 1951):5-6. The article noted that Menninger had been invited to Saskatchewan by McKerracher.
102. Donald McKerracher, "A New Program in the Training and Employment of Ward Personnel", *American Journal of Psychiatry* (Oct 1949): 259-264. His explanation for the high rate of hospitalization was a lack of trained nurses on the mental hospitals' staffs.
103. Ibid., 259.
104. SAB, SRNA, R-993, 43F (4.2-9), Letter from McKerracher to Ellis, Dec 23, 1946. With Mindel Sheps gone nothing was accomplished. It made sense to go back to the SRNA.
105. Ibid.
106. SAB, SRNA, R-993, 43F (4.2-9), Letter from Ellis to President of SRNA, Mrs. G. Harrison, First Vice-President Miss E. Pearston, Second Vice-President Sister Perpetua and SRNA councillors, Dec 27, 1946. At this time the Douglas Government decision had not been made around the licensing of the professions and Ellis did not wish the SRNA to appear exclusionary. She was willing to take a risk on a shorter than recommended affiliation.
107. SAB, SRNA, R-993, 43F (4.2-9), Letter from E. Pearston, First Vice-President to K. Ellis, Dec 30, 1946. "By this" she meant an 18 month general affiliation.
108. SAB, SRNA, R-993, 43F (4.2-9), Letter from Ellis to Dr. McKerracher, Jan 23, 1947.
109. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Dr. McKerracher, Feb 4, 1947. It was now clear to McKerracher that because the Saskatchewan students were already staff, affiliations outside of the mental hospital were problematic.
110. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Dr. McKerracher, June 18, 1947.
111. For Laura Fitzsimmons, the conditions of a mental hospital were a deciding factor as to whether there was an opportunity for nurse training. See Laura Fitzsimmons, "Facts and Trends in Psychiatric Nursing", *American Journal of Nursing* (Aug 1944):732-35.
112. UofS Archives, Examining Board for Psychiatric Nurses, Outline of training program, D. McKerracher, 1948.
113. McKerracher, 259-264.
114. WGH Alumnae Archives, Journal Collection, Anonymous, "Is This The Answer?", *The Canadian Nurse* (Sept 1949):668-69. The APA conference was held in Montreal which was home to the CNA's office. There is a possibility that Elsie Ogilvie was the anonymous writer. She was by then teaching at McGill and had not been impressed with the Saskatchewan program when she surveyed it for the Canadian government.
115. Ibid. There were no further articles or letters to the editor following this report.
116. SAB, R-11-14-19, 1944-52, Memo to T.C. Douglas from Dr. Hames, Deputy Minister, Public Health re-attached minutes from meeting about new training program, May 7, 1947. Hames and Douglas were by then more concerned with the realities of the need for a better training program than with the 1945 ideals of what the training should

look like.
117. SAB, 251, RC (M13), Henry Sigerist, *Saskatchewan Health Services Survey Commission* (Regina: King's Printer, 1944), 11-12.
118. McKerracher, 261-63. Also see SAB, SRNA, R-993, 43F (4.2-9), Letter to Ellis from McKerracher, Dec 3, 1948.
119. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dr. McKerracher from K. Ellis, July 9, 1947. Ellis thanked him for telling her the opinions held outside the province re-mental hospital training.
120. Anonymous, 688-89.
121. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dr. McKerracher from K. Ellis, July 9, 1947. Ellis suggested that she, McKerracher and Deputy Minister Hames should discuss "the question of affiliation".
122. NAC, RG29, Vol. 305, File 335-5-22, News Release, April 20, 1947, Regina.
123. UofS Archives, Examining Board for Psychiatric Nurses, Outline of the training program, D. McKerracher, 1948.
124. UofS Archives, Examining Board for Psychiatric Nurses, Recruitment of Psychiatric Aides, C. Smith, 1948.
125. McKerracher, 261.
126. SAB, R-11, 14-38, Letter to Premier Douglas from Lloyd Gardiner, May 17, 1947.
127. UofS Archives, Examining Board for Psychiatric Nurses, Outline of the training program, D. McKerracher, 1948.
128. UofS Archives, Senate Minutes, Nov 26, 1948. See also SAB, R-11, 14-84, Memo from T.J. Bentley to Dr. Mott, May 3, 1951. This memo clarified that provincial monies got the new program going but new funding from the federal mental health grant assisted after 1950.
129. UofS Archives, Examining Board for Psychiatric Nurses, Outline of the training program, D. McKerracher, 1948.
130. SAB, R-11-14-19, 1944-52, Newspaper clipping from *Regina-Leader Post*, "Mental Hospital Equipment Announced", no author, Jan 31, 1950. Article discussed Health Minister Paul Martin's national mental health grant of $13,900 for Saskatchewan's mental hospitals. Some was used for nursing instructor position.
131. UofS Archives, Examining Board for Psychiatric Nurses, An Outline of the Staff Training Program, Saskatchewan, Dr. F. Lawson, 1948.
132. Ibid.
133. Ibid.
134. SAB, R-11, 14-38, 1948-49, article written by Dr. McKerracher for *The Psychiatric Aide*, Nov 1947, "A Synopsis of Efforts to Improve Training".
135. RPNAS Archives, D. McKerracher, "Nursing in Saskatchewan", in *Ten Giant Steps* ed. Saskatchewan Division, Canadian Mental Health Assoc. (Regina: CMHA, 1959), 26.
136. UofS Archives, Examining Board for Psychiatric Nurses, An Outline of the Staff Training Program, Saskatchewan, Dr. F. Lawson, 1948.
137. Ibid.
138. UofS Archives, Examining Board for Psychiatric Nurses, Examinations for Aides, 1949. Of the six examiners, only one was a nurse.

139. SAB, R-11, 14-38, 1948-49, article written by Dr. McKerracher for *The Psychiatric Aide*, Nov 1947, "A Synopsis of Efforts to Improve Training".
140. UofS Archives, Examining Board for Psychiatric Nurses, Recruitment of Psychiatric Aides, C. Smith, 1948.
141. RPNAS Archives, L. Ellis, *Psychiatric Nursing in Saskatchewan. A Strategy for Development* (Regina: Dept. of Public Health, 1971), 17-18.
142. PAM, S16-19-1, Health and Welfare Minister's Office Files, 1944-49, Off-Site, Temporary Box 34, a separate page "Comparative Rates for Institutional Nurses", 1948, listed Saskatchewan and other provinces.
143. SAB, R-11, 14-38, 1948-49, article written by Dr. McKerracher for *The Psychiatric Aide*, Nov 1947, "A Synopsis of Efforts to Improve Training".
144. RPNAS, North Battleford Archives, Graduations, 1949.
145. RPNAS, North Battleford Archives, Graduations, 1947.
146. SAB, R-11, 14-38, 1948-49, article written by Dr. McKerracher for *The Psychiatric Aide*, Nov 1947, "A Synopsis of Efforts to Improve Training". Sometimes the term used was psychiatric aide.
147. RPNAS Archives, L. Ellis, *Psychiatric Nursing in Saskatchewan. A Strategy for Development* (Regina: Dept. of Public Health, 1971), 17-18.
148. McKerracher, 259-260.
149. SAB, R-11-14-19, 1944-52, Memo to T. D. Bentley, Minister from G. McKerracher re-progress report, Feb 10, 1951.
150. Ibid. Officially grade 11 was required but "unofficially" men with grade 10 were sometimes recruited. See for example SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. According to Vowles men with grade 10 were not turned away.
151. SAB, R-11-14-19, 1944-52, Copy of article "Province's Mental Hospital Training Course Licking Staff Shortage", *Regina-Leader Post*, Jan 26, 1950, no author. McKerracher told the reporter that other provinces needed to use his program.
152. McKerracher, 259; SAB, R-11-14-37, Dr. Karl Menninger, "Canada Trip", *TPR* (Oct 1951):5-6. The article noted that Menninger had been invited to Saskatchewan by McKerracher.
153. SAB, R-11-14-19, 1944-52, Memo to T. D. Bentley, Minister from G. McKerracher re-progress report, Feb 10, 1951.
154. APA Archives, Nursing, Site Visits, Box 6, Folder 77, Canadian Hospitals, 1949.
155. APA Archives, Nursing, Box 1, Folder 16, Committee on Psychiatric Nursing, 1942-49 and Folder 18, 1952. McKerracher was on this committee in the late 1940's and his training program was often mentioned in minutes. However at the May, 1952 meeting committee members (new) decided not to adopt the Saskatchewan model.
156. APA Archives, Nursing, Site Visits, Box 6, Folder 77, Canadian Hospitals, 1949.
157. SAB, R-11, 14-37, Memo to T.C. Douglas from Deputy Minister C. Hames re-APA's interest, Jan 14, 1949.
158. SAB, R-11-14-19, 1944-52, Memo to T.J. Bentley from D. McKerracher, April 10, 1951.
159. SAB, R-11-14-19, 1944-52, Memo to T.C. Douglas from Dr. C. Hames re-

attached minutes, May 7, 1947.
160. Ibid. Dr. S. Lawson was so annoyed that he wrote a sarcastic letter to Ogilvie. See NAC, RG29, Vol. 332, 436-2-5, Mental Health Div., Nursing, Letter from Lawson to Ogilvie, Dec 10, 1947. She had sent him a suggested book list which he adopted as his own work.
161. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947.
162. NAC, RG29, Vol. 305, File 335-5-22, News Release, April 20, 1947, Regina. In his press release, Premier Douglas was not clear about what was meant by "professional status". However, within a month of the press release the government passed a Bill of Rights Act which included the right to join professional associations and trade unions. Perhaps he was only clearing the way for the attendants to later join or form a professional association. See Statutes of the Province of Saskatchewan, An Act to Protect Certain Civil Rights, Chapter 70, 260, 1947.
163. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. Prior to his death Vowles wrote his memoirs.
164. SAB, SRNA, R-993, 39A (3.2-2-2), A copy of Bill 69 in SRNA file. The applicants signed themselves as "graduate attendants".
165. UofS Archives, Examining Board for Psychiatric Nurses, Outline of the training program, D. McKerracher, 1948. He referred to the nurses as semi-professional.
166. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
167. Ibid. Most of the men who studied in the older shorter program had only grade 8 or 9.
168. Ibid.
169. SAB, R-33.5, 109 (13-5-2), Letter to Dr. M. Shumiatcher, Premier's Office, from L. Gardiner, Local 3, April 2, 1947.
170. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
171. Ibid; Also see Dickinson, 107. Dickinson reported that the union men felt threatened with the new emphasis of training on therapy. They were more comfortable with custodial care.
172. Peter Nolan, *A History of Mental Health Nursing* (New York: Chapman and Hall, 1993), 7-8. Psychiatric nursing was an American term and not used in Britain unless a nurse was doubly qualified–general and mental. Psychiatric nurses in Britain were involved in the medical care of patients and were said to regard mental nurses as inferior to them.
173. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
174. SAB, R-33.5, 109 (13-5-2), Letter to Lloyd Gardiner from M. Shumiatcher, April 14, 1947. Shumiatcher had just completed his work on the royal commission at the North Battleford Mental Hospital and might have been concerned with yet another physician exerting authority over the attendants. Further, under the province's new Bill of Rights Act, he knew that the attendants had a right to join a professional association.
175. Ibid.
176. SAB, R-33.5, 109 (13-5-2), Letter to Dr. M. Shumiatcher from W. Vowles, June

10, 1947. Vowles botched attempt was still in this file.
177. SAB, R-33.5, 109 (13-5-2), Letter to Mr. Vowles from M. Shumiatcher, June 24, 1947. Shumiatcher was directing Vowles and Gardiner, step by step. He kindly withheld criticism of Vowles' work.
178. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
179. Ibid.
180. Ibid.
181. SAB, R-33.5, 109 (33-5-2), Letter to Dr. Shumiatcher, Counsel to Premier, from Mr. Gardiner, Jan 19, 1948. File also contained a copy of the SRNA Act, 1930, 1940 with Shumiatcher's changes in red ink. The new association did not change any of Shumiatcher's work on their proposed bill.
182. Ibid.
183. SAB, R-335, 109 (13-5-2), Letter to Mr. L. Gardiner from T.C. Douglas, Jan. 22, 1948.
184. SAB, R-33.5, 109 (13-5-2), Memo to Dr. M. Shumiatcher from T.C. Douglas, Jan 22, 1948. Douglas may have been aware that Shumiatcher wrote the proposed bill but he did not put same in writing.
185. SAB, R-33.5, 109 (13-5-2), Memo to Dr. D. McKerracher from M. Shumiatcher, Premier's Office, Feb 13, 1948.
186. SAB, R-11, 14-37, Letter to Tommy Douglas from Alex Connon, Sept 20, 1947.
187. SAB, R-11, 14-37, Letter to A. Connon from T.C. Douglas, Sept 26, 1947.
188. SAB, R-11, 14-38, Letter to Premier Douglas from Lloyd Gardiner, May 17, 1947.
189. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis, Registrar to Miss E. James, President, March 3, 1948. Ellis said that McKerracher came to her office with news of the proposed Act because it affected the SRNA. The delay might have been related to one of McKerracher's trips outside the province. Further, Ellis' office was in Saskatoon and McKerracher was located in Regina. This might have been his first opportunity to speak with her. Other researchers have suggested that Dr. McKerracher supported the creation of "psychiatric nurses" because the SRNA archive data were not reviewed. For example see Dickinson, 110; Susan Taylor Wood, "Changing Times: A Historical Review of Psychiatric Nursing Education in the Province of Saskatchewan" (Master's Thesis, University of Regina, 1998).
190. SAB, SRNA, R-993, 39A (3.2-2-2), Letter to Miss K. Ellis from Dr. G. McKerracher, March 15, 1948.
191. SAB, SRNA, R-1271, 54, Council Minutes, Meeting March 5, 1948, Ethel James outlined what occurred when they met with Hames.
192. SAB, R-33.5 III 100 (13-4-2-1), Douglas Papers, Letter to Mr. L. Gardiner from C. Hames, Deputy Minister, June 22, 1946.
193. SAB, R-11, 14-31, Memo to T.C. Douglas from Dr. M. Sheps, March 15, 1946. Also see telegram to K. Ellis from Premier Douglas, March 20, 1946. In 1946 Ellis told Douglas that she accepted the government's need to employ other groups of nurses besides registered nurses, especially since RNs were in short supply post-war.
194. SAB, SRNA, R-1271, 54, Council Minutes, Meeting March 5, 1948. Ellis reported to council members re-her discussion.

195. SAB, SRNA, R-1271, 54, Council Minutes, Meeting March 5 (evening), 1948.
196. SAB, R-11, 14-31, Letter to K. Ellis from Premier Douglas, Oct 12, 1944.
197. Mombourquette, 76-80.
198. SAB, SRNA, R-993, 43F (4.2-9), Letter to T.C. Douglas from K. Ellis, Oct 25, 1944. Part of the inaction was related to Sheps' departure. Also see letter from Ellis to Dr. McKerracher, Jan. 23, 1947.
199. SAB, R-33.1, 826 (35-14) A, Letter from J. Corman, Attorney General, Saskatchewan to the Premier and Ministers, Jan 2, 1947 re-proposed Bill regulating the professions.
200. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to Premier Douglas, March 8, 1948. Ellis was unhappy that Douglas left the meeting and substituted with Alex Connon. No doubt Douglas wanted to separate himself from the issue. She was desperate that he get their message.
201. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to Ethel James, March 8, 1948. The letter to Douglas was attached for James' signature. Ellis was again grasping onto the educational ideal of affiliations for general students even though this did not meet the reality of the mental hospital situation. It was never proposed.
202. SAB, SRNA, R-993, 39A (3.2-2-2), Letter to Miss Ellis from Committee Clerk, March 12, 1948. Ellis asked for postponement until Monday, March 15 but the new date was Wednesday March 17, 1948.
203. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
204. SAB, SRNA, R-993, 39A (3.2-2-2), Letter to Miss K. Ellis from Dr. G. McKerracher, March 15, 1948. Also see SAB, SRNA, R-993-39F (3.2-8-2), Letter to Miss Motta, Miss James and Sister Perpetua from K. Ellis, March 14, 1948.
205. SAB, SRNA, R-993-39F (3.2-8-2), Letter to Miss Motta, Miss James and Sister Perpetua from K. Ellis, March 14, 1948.
206. The meeting in Winnipeg was why she had requested a March 15 postponement. But the new March 17 date conflicted with the Winnipeg meeting. Since she had to be in two locations on March 17 the only thing she might have done was remain in Regina until the law amendments committee meeting was finished. But March 17 was already planned as her travel day.
207. Sharon Richardson, "Lively Combat, Kathleen Ellis and the Canadian Nurses Association's Lobby during the Second World War", *Canadian Bulletin of Medical History* 17, 1-2 (2000):209-227.
208. WGH Nurses Alumnae Archives, Journal Collection, K. Ellis, "Saskatchewan Registered Nurses' Association", *The Canadian Nurse* (June 1948):496-7. Also see Robinson, *The First Fifty Years*, 164. Robinson noted that 1948 was an especially busy year for Ellis and the SRNA.
209. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to Ethel James, Miss Motta, Sister Perpetua, March 14, 1948.
210. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. There was some exaggeration by Vowles re-his recollection of a "strong gathering" of RN's. Only James, Motta and Perpetua appeared and Ellis was on her way to Winnipeg. See SAB, R594, Box 22, Sessional Papers #67, 71, 1948.
211. SAB, SRNA, R-1271, 54, Council Minutes, Meeting May 30, 1948.

212. SAB, R-33.5, 109 (13-5-2). Copies of SRNA Act 1930, 1940 with Shumiatcher's changes in red ink.
213. SAB, SRNA, R-993, 39A (3.2-2-2), Letter to McKerracher from Ellis, April 6, 1948. Also see SAB, SRNA, R-993-39 F (3.2-8-2), Letter to Miss Wilson from K. Ellis, Jan 2, 1951. Ellis later wondered if the SRNA had been "used" to oppose the Bill as McKerracher did not attend the law amendments committee meeting on March 17. She was unaware that his goal to expand his training program outside the province was threatened by the new designation, also causing his manipulation.
214. SAB, SRNA, R-1271, 54, Council Minutes, Meeting May 30, 1948. Haimes left Saskatchewan shortly after.
215. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
216. SAB, SRNA, R-993-36 (3.1-3)R, Letter to Mr. A. Weir, Registrar, UofS, from K. Ellis, SRNA.
217. SAB, R-33.5, 109 (13-5-2). Copies of SRNA Act 1930, 1940 with Shumiatcher's changes in red ink. See copies of new Act. The UofS examined general nursing specialties.
218. SAB, R594, Box 22, Session 1948, 5th Session of 10th Legislature. In contrast it took the SRNA three years before its Act was passed in 1917. See Marguerite Robinson, *The First Fifty Years* (Regina:SRNA, 1967), 44-46.
219. SAB, R-33.5, 109 (13-5-2), Letter from W. Vowles to Dr. Shumiatcher, March 28, 1948. In 1998 Dr. Shumiatcher was honoured with a certificate of recognition from the R.P.N.A.S. as "one who was instrumental in the development of the professional association". See *Fifty Years in Review...Celebrating Our 50th Anniversary, 1948-1998* (Saskatoon: RPNAS, 1998), 19-20.
220. SAB, R11, 14-17, Letter to Premier Douglas from W. Vowles, President of Local 3, May 25, 1948.
221. SAB, R11, 14-17, Memo to Premier Douglas from G. Darby, Acting Deputy Minister, Aug 30, 1948.
222. SAB, R11, 14-17, Memo from Premier Douglas to Dr. McKerracher, May 25, 1949.
223. SAB, R11, 14-17, Memo to Premier Douglas from G. Darby, Acting Deputy Minister, Aug 30, 1948.
224. Ibid; SAB, R11, 14-17, Memo from McKerracher to Premier Douglas, June 11, 1949.
225. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. Vowles recalled that since union agreements were accepted by "order in council" it was a legal term and their Act was not opened.
226. SAB, SRNA, R-993-39F (3.2-8-2), Letter to Miss M. Forshner, Secretary, from Dr. McKerracher, Feb 8, 1950. This letter was sent to the SRNA in error and provided Ellis with unsolicited information.
227. SAB, SRNA, R-993-39F (3.2-8-2), Letter to Dr. McKerracher from K. Ellis, Feb 14, 1950.
228. SAB, SRNA, R-993-39F (3.2-8-2), Letter to K. Ellis from G. McKerracher, Feb 17, 1950. Ellis did not trust what he said in this letter. See letter to Miss Wilson from Ellis, Jan 2, 1951.

229. RPNAS Archives, E. Kahan, "The Psychiatric Nurse's Story", in *Ten Giant Steps* ed. Saskatchewan Division, Canadian Mental Health Assoc. (Regina:CMHA, 1959), 8-11. Kahan interviewed Dr. McKerracher.
230. SAB, R-11-14-37, Dr. Karl Menninger, "Canada Trip", *TPR* (Oct 1951):5-6. Menninger was McKerracher's guest and was told the psychiatric nurses were "psychiatric aides".
231. SAB, R-11, 14-37, Ward Staff Training in Mental Hospitals, A Report, c. 1950. As commissioner of mental services, the psychiatric services branch fell under McKerracher.
232. UofS Archives, Board of Examiners for Psychiatric Nurses, Letter to Dr. McKerracher from Dean Lindsay, Medicine, Oct 15, 1948. Also see letter to Dean Lindsay from K. Ellis, Dec 3, 1948. There was no information sent from the new psychiatric nurses association because nothing had been developed by members.
233. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dean Lindsay, Chairman, Board of Examiners from K. Ellis, Jan 13, 1949. Less than two years earlier McKerracher had turned down the idea of affiliation for the mental hospital students, believing it too complicated to arrange. Here Ellis is trying to get in "through the backdoor" by influencing Dean Lindsay around the new curriculum. Her advocacy on behalf of the mental hospital students was evident.
234. UofS Archives, Senate Minutes, Nov 26, 1948. This information was a piece in Ellis' lobby as the Senate and Dean Lindsay knew little about the new profession.
235. UofS Archives, Senate Minutes, Jan 30, 1949 and May 11, 1949. It was rubber stamped.
236. Ibid. Dr. Lindsay let McKerracher and the other psychiatrists retain authority over their mental hospital training program. Even though Ellis raised some red flags they were ignored by the Dean of Medicine. She was a female nurse and they were male physicians.
237. UofS Archives, Board of Examiners for Psychiatric Nurses, Minutes, Sept 25, 1950.
238. UofS Archives, Board of Examiners for Psychiatric Nurses, Letter to Dean Lindsay from G. McKerracher, Dec 7, 1950. It was noteworthy that the psychiatric nurses went to McKerracher for help when just a few years earlier the fledgling group wanted nothing to do with doctors.
239. UofS Archives, Board of Examiners for Psychiatric Nurses, Letter to Dr. G. McKerracher from Dr. Lindsay, Dec 20, 1950.
240. UofS Archives, Board of Examiners for Psychiatric Nurses, Letter to President Thompson from Dr. Lindsay, Dec 14, 1950. Copeman's "stand" was that she refused to raise failing grades.
241. Pat Schwirian, *Professionalization of Nursing. Current Issues and Trends* (New York: Lippincott, 1998), 4-5. Schwirian reviewed the common characteristics developed by Flexner, Etzioni, Parsons and Goode.
242. SAB, GR164, R349, Kahan Papers, File Ie, Interview with Kay Fey, March 23, 1973.
243. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964. Vowles made no apologies for this scenario and made it clear that a few union men "ran the show" at the end of the decade.

244. See for example Health Survey Committee, *Saskatchewan Health Survey Report: Health Programs and Personnel* (Regina: Sask. Government, 1951).
245. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to Premier Douglas, March 8, 1948.
246. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from Dr. D. McKerracher, Oct 21, 1949.
247. NAC, RG29, Vol. 335, 436-5-5, Part 1, Mental Health Division, Nursing, Letters to Ellis from E. Ogilvie, RN, Jan 29 and Feb 6, 1948. Letter from Ellis to Ogilvie Jan 21, 1948.
248. SAB, SRNA, R-993, 43F (4.2-9), Letter to Ellis from McKerracher, May 4, 1949.
249. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dr. F. Mott, Deputy Minister, Public Health from Lola Wilson, Registrar, SRNA, June 13, 1951.
250. SAB, SRNA, R-1271, 54, Council Minutes, Meeting May 19, 1948.
251. SAB, R-11-14-37, Memo from Dr. McKerracher to Mr. Bentley, Health Minister, Feb 17, 1950. McKerracher explained who Stokes was and the relevance of the visit.
252. SAB, SRNA, R-993, 39F (3.2-8-2), Letter to K. Ellis from Ella Howard, University of Toronto, March 13, 1950. Howard attached the article, March 2, 1950.
253. Health Survey Committee, *Saskatchewan Health Survey Report: Health Programs and Personnel* (Regina: Sask Government, 1951), 90-97.
254. SAB, SRNA, R-993, 39F (3.2-8-2), Letter to Ella Howard, Professor of Nursing, from K. Ellis, March 16, 1950. Here Ellis perceived the program's graduates as trained attendants but expressed no outrage that the CCF Government designated them as professional nurses. Just two years previously she was so agitated about this issue that she phoned and wrote Premier Douglas. Her letter revealed that she had become realistic about the training per se, but not about the profession.
255. SAB, SRNA, R-993, 39F (3.2-8-2), Letter to Ellis from E. Howard, March 25, 1950. SAB, R-326, 110 (6-1-2)F, Letter to Ellis from Dr. F. Mott, Acting Deputy Minister, Public Health, June 19, 1950. Mott acknowledged her upcoming retirement.
256. Anna Shynkaruk, tape-recorded interview by writer, North Battleford, SK, Aug 9, 1999.
257. Selma Loewen (nee Epp), tape-recorded interview by writer, Winnipeg, MB, Sept 29, 1999; Mary Gerbanski, tape-recorded interview writer, North Battleford, SK, August 10, 1999.
258. Shynkaruk interview.
259. RPNAS, North Battleford Archives, Graduations 1947-1953.
260. Ibid.
261. Dorothy Mulder (nee Campbell), tape-recorded interview by writer, Winnipeg, MB, Sept 6, 1999.
262. Elsie Pernala (nee Maksymchuk), tape-recorded interview by writer, North Battleford, SK, Aug 9, 1999.
263. Mabel Hubbs (nee Broley), tape-recorded interview by writer, Weyburn, SK, Aug 12, 1999.
264. Grace Kurtz (nee Murdoch), tape-recorded interview by writer, Weyburn, SK, Aug 12, 1999.

265. Loewen interview.
266. Gerbanski interview; Loewen interview.
267. Mulder interview.
268. Pernala interview.
269. Shynkaruk interview.
270. Hubbs interview.
271. Mulder interview.
272. Gerbanski interview; Pernala interview.
273. Mulder interview.
274. Shynkaruk interview.
275. Loewen interview; Kurtz interview.
276. Gerbanski interview; Shynkaruk interview.
277. Pernala interview; Shynkaruk interview.
278. Kurtz interview.
279. Shynkaruk interview.
280. Mulder interview.
281. Gerbanski interview; Pernala interview; Kurtz interview.
282. Loewen interview; Gerbanski interview.
283. Kurtz interview; Pernala interview.
284. Loewen interview.
285. Shynkaruk interview.
286. Ibid.
287. Gerbanski interview; Hubbs interview.
288. Mulder interview.
289. Shynkaruk interview.
290. Loewen interview.
291. Gerbanski interview; Hubbs interview; Kurtz interview.
292. Pernala interview; Shynkaruk interview.
293. Mulder interview.
294. Kurtz interview.
295. Pernala interview; Shynkaruk interview; Kurtz interview.
296. Loewen interview; Mulder interview.
297. Shynkaruk interview; Gerbanski interview.
298. Loewen interview. Selma Loewen left the province.
299. Shynkaruk interview; Pernala interview.
300. Shynkaruk interview; Gerbanski interview; Loewen interview.
301. Loewen interview. She was finally hired at Deer Lodge Hospital as an unlicensed practical nurse.
302. SAB, R-999, 22 (172D3), Report of Commission of Inquiry into the Administration of the Provincial Mental Hospital, North Battleford, April 8, 1946. Commissioners Shumiatcher, M., Bethell, W., Williams, D.
303. Health Survey Committee, *Saskatchewan Health Survey Report: Health Programs and Personnel* (Regina: Sask Government, 1951), 90-97.
304. Ibid.
305. SAB, SRNA, R-993, 43F (4.2-9), Letter to T.C. Douglas from K. Ellis, Oct 21, 1944; Letter from Ellis to McKerracher, Jan 23, 1947.

306. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to Premier Douglas, March 8, 1948.
307. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
308. Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), 242-243, 260-261; Janet Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta, 1859-1996* (Vancouver:UBC/UofA Press, 1998), 54-61.
309. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 2, The West", *Liberty* (Feb 8 1947):8,9, 38-41.
310. PAM, S-16-19-11, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, 1944-49, Editor, "An Excellent Program", *Regina Leader-Post* (May 6 1947). Newspaper clipping attached to memo sent to Schultz.
311. PAM, S-16-19-11, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, 1944-49, Memo to Hon. J. McDiarmid from Ivan Schultz, May 21, 1947.
312. Le Bourdais, 38; PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, 1944-9, Letter to W. Metcalfe, Winnipeg Free Press from Ivan Schultz, April 6, 1949. Metcalfe needed data from Schultz for a series later published in the newspaper.
313. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, 1944-9, Letter to W. Metcalfe, Winnipeg Free Press from Ivan Schultz, April 6, 1949.
314. PAM, GR18B2, Box 3, Letter from Baragar to J. Fleming, Civil Service, Sept 11, 1926.
315. PAM, RG18B2, Box 4, Brandon Hospital for Mental Diseases, 1926, Data re-nurse's duties, Oct 31, 1926.
316. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1926-7, 5-6; McKee, BMHC, SB17, Graduations to 1948, Letter from Dr. Pincock to Hon. R. Hoey re-school of nursing, May 18, 1931.
317. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1941-2. Pincock did not specify how many registered nurses joined the RCAMC. Also see McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):7.
318. McKee, BMHC, SB3, File 13, Letter from Dr. S. Schultz, Brandon to Dr. F. Jackson, Deputy Minister, Health, re-shortage of nurses at the Brandon facility, Oct. 12, 1947.
319. McKee, BMHC, SB3A, File 12, Letter from Dr. Pincock to Drs. Barnes and Bristow re-nurse attendants, Dec 4, 1941.
320. Ibid.
321. PAM, S-16-19-11, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, 1944-49, Memo to Hon. J. McDiarmid from Ivan Schultz, May 21, 1947.
322. PAM, RG18B2, Box 3, Letter from Baragar to J. Fleming, Civil Service, re-head nurses, Sept 11, 1926.
323. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):7; MARN Archives, 47-24-058, Board Meeting Minutes, May 11, 1942.

324. Ibid.
325. WGH Alumni Archives, "News", *The Canadian Nurse* (Feb 1931):94. Also see Janet Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta*, 1859-1996 (Vancouver: UBC/UofA Press, 1998), 220.
326. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):7; MARN Archives, 47-24-058, Board Meeting Minutes, May 11, 1942. See Chapter 3 for a detailed description of MARN's past exclusionary tactics.
327. PAM, MG10B11, Box 17, Minutes, Board of Directors, WGH, Nov 3, 1942, sub-committee, nursing, and June 25, 1943.
328. Sharon Richardson, "Lively Combat, Kathleen Ellis and the Canadian Nurses Association's Lobby during the Second World War", *Canadian Bulletin of Medical History* 17, 1-2 (2000):209-227.
329. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1942,6.
330. PAM, GR1611, RG18, B2, Box 3, An Act to Amend an Act Respecting the Manitoba Association of Graduate Nurses, 1927. Eighteen months was the requirement in Manitoba.
331. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):7; MARN Archives, 47-24-058, Board Meeting Minutes, May 11, 1942.
332. SAB, SRNA, R-993, 43F (4.2-9), Letter from Ellis to McKerracher, Jan 23, 1947. Also see letter from Margaret Street, MARN to Ellis, Feb 7, 1945. Street attached the WGH/Brandon Mental Hospital curriculum.
333. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from McKerracher, June 18, 1947. Also see McKerracher, 259-260. McKerracher consistently focused on student service.
334. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from McKerracher, June 18, 1947.
335. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1942,6.
336. PAM, G1262, GR1551, Health and Welfare Minister's Office Files, Papers re-Administration and Nursing, Progress Report, Dr. T. Pincock, Oct 11, 1949.
337. NAC, RG29, Vol. 305, File 335-5-22, News Release, April 20, 1947, Regina.
338. McKee, BMHC, SB11, File 1, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1942.
339. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter from C. Rice-Jones, Civil Service Commissioner to Dear Madam, July 17, 1946.
340. McKee, BMHC, SB11, File 1, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1942.
341. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1942,4.
342. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):7.
343. APA, Nursing, Site Visits, Box 13, File 259, Brandon Hospital for Mental Diseases, Report of Accredited Nursing School, April 21, 1948. Lela Anderson visited for the first time and reviewed the mental and combined courses.
344. NAC, RG29, Vol. 335, 436-5-5, Pt. 1, Mental Health Division, Letter to Elsie Ogilvie from Elva Cranna, superintendent of nurses, July 23, 1947. Cranna discussed Ogilvie's visit to Brandon earlier in 1947 and of the problem re-students' finances.

345. McKee, BMHC, SB6, File 6, Nursing Programs, Summary, 1942-1952. This was more than the minimum daily average lecture time recommended by the MARN – 30 minutes.
346. McKee, BMHC, SB11, File 1, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1942.
347. WGH Alumnae Archives, Affiliations, Brandon Mental Hospital, 1945, Theoretical Instruction.
348. WGH Alumnae Archives, Affiliations, Brandon Mental Hospital, 1945, Ward Experiences.
349. McKerracher, 262. If the Brandon students covered 650 hours of lectures over two years McKerracher could have offered his 500 hours over the same period.
350. McKee, BMHC, SB11, File 1, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1942.
351. PAM, H16-19-1A, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Brandon, Memo from Dr. Little, Assistant Superintendent to Dr. S. Schultz, Superintendent, Jan 18, 1944.
352. McKee, BMHC, SB14, File 4, Dorothy Cassan's lecture notes, 1944.
353. McKee, BMHC, SB47, File 2, *Winnipeg Psychopathic Hospital Handbook, Nursing Procedures*, c.1950, 16-17.
354. S. Schultz and H. Evans, "Prefrontal Leucotomies, Seven Years' Experience with One Hundred and Thirty Three Cases", *The Manitoba Medical Review* 33,5 (1953):243-47.
355. McKee, BMHC, SB47, File 2, *Winnipeg Psychopathic Hospital Handbook, Nursing Procedures*, c.1950, 16-17.
356. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1945, 1946, 1947.
357. PAM, H16-19-1A, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Brandon, Letter from Stuart Schultz, Brandon to brother Ivan Schultz, Minister of Health and Welfare re-graduation, March 18, 1947. Also see WGH Alumnae Archives, Yearbooks, *Blue and White* (Winnipeg: WGH, 1945 through 1949).
358. McKee, BMHC, SB17, no file name, Newspaper clipping dated 1949 "Mental Hospital Graduation Exercises Attended by Large Crowd in First United Church". Miss Bertha Pullen, WGH represented that school. The class of 1945 was the only class which joined the WGH graduation ceremony and became alumni. It is not known why this differed in the years following. Anne Crossin, interview by writer, Winnipeg, MB, Nov 5, 2001.
359. McKee, BMHC, SB17, Baragar Award File, Letter from Dr. Baragar, Alberta to Dr. T. Pincock, Brandon, March 14, 1931. Baragar requested that the gold medal go to a student in the combined course and the silver to a mental nursing student. However since there was no combined course in 1931, only the silver medal was created. If his wishes had been followed the gold would have been developed for the 1945 graduation.
360. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Mr. Schultz, Minister of Health and Welfare from E. MacKay, Personnel Dept, Health, Oct 2, 1947. Eight new graduates were offered administrative and teaching positions.
361. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare

Minister's Office Files, Psychiatry, Letter to Dr. Jackson, Deputy Minister, Health, re-ward nursing personnel, Nov 25, 1944.
362. Ibid.
363. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Copy of an article by H.B., untitled, *Winnipeg Free Press* (April 16 1947). The report described a lengthy debate in the Manitoba Legislature which focused on mental hospital care and nurse training for same.
364. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Dr. S. Schultz from Ivan Schultz with copy of letter from Mr. Rice-Jones, July 17, 1946. It described the three schools' programs. Barnes had superintended at the Selkirk institution since the end of the First World War.
365. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Memo to his own file re-a meeting held between himself (Deputy Minister Dr. Jackson), Dr. Barnes and Dr. Bristow (Portage), March 2, 1946.
366. Ibid.
367. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter from Dr. Bristow, Portage School, to Dr. Ivan Schultz, Health Minister, April 29, 1946.
368. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1945,4.
369. PAM, H-16-19-1A, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Brandon, Memo from Dr. Little, Assistant Superintendent to Dr. S. Schultz re-nursing shortage, Jan 18, 1944.
370. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter from Dr. S. Schultz to Mr. Cecil Rice-Jones, Dec 2, 1946.
371. PAM, S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter from Rice-Jones to Ivan Schultz, April 22, 1946.
372. MARN Archives, 47-24-058, Annual Meeting Report, 1948, 14. The shortage was termed "our serious problem".
373. Ibid; PAM, MG10, B11, Box 36, Winnipeg General Hospital, Ann Henry, "Nurses, Authorities Clash Over Hospital Training Conditions", *Winnipeg Citizen* (July 1948). Young women continued to enter training schools but this did not meet the demand for nurses.
374. PAM S16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter from Cecil Rice-Jones, Civil Service to Ivan Schultz, Health Minister, re-nurses for Portage School, June 27, 1945. Rice-Jones cited all the agencies and individuals he requested assistance from, including the MARN.
375. PAM, GR157, H-8-5-2G, Off-Site, Box 15, Health and Welfare Minister's Office Files, "Report of the Rockefeller Foundation on Training Requirements of the Health Services Act, Manitoba", Oct 1946. Also see George Weir, *Survey of Nursing Education in Canada* (Toronto: MacMillan Co., 1932).
376. Ibid. The report contrasted this arrangement with the majority of Manitoba schools where service demands meant no correlation between theory and practise.
377. MARN Archives, 47-24-058, Board Meeting Minutes, Aug 29, 1946. The Board

was made aware of 35 surgical beds closed due to a shortage of RNs.
378. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Copy of an article by H.B., untitled, *Winnipeg Free Press* (April 16 1947). The reporter described a lengthy debate in the Manitoba Legislature which focused on mental hospital care and the shortage of nurses for same.
379. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Memo to Miss E. Russell, Director of Public Health Nursing from L. Johnston, District Supervisor re-request from Mr. Schultz and Dr. Pincock to find recruits.
380. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Dr. S. Schultz from Ivan Schultz with a copy of the letter sent to "Dear Madam" from Schultz and Rice-Jones, July 17, 1946.
381. Ibid.
382. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Dr. T. Pincock from Dr. S. Schultz re-pupil nurses, April 18, 1946.
383. PAM, GR157, H-14-21-1, Off-Site, Temp. Box 14, Health and Welfare Minister's Office Files, General, Letter to Mr. I. Schultz, Minister from Dr. G. Fiddes, Medical Superintendent, Brandon General Hospital, Aug 30, 1946.
384. Weir, 14-203.
385. Richardson, 209-227.
386. PAM, MG10, B11, Box 36, Winnipeg General Hospital, Ann Henry, "Nurses, Authorities Clash Over Hospital Training Conditions", *Winnipeg Citizen* (July 1948).
387. MARN Archives, 47-24-058, Board Meeting Minutes, Feb 16, 1949.
388. McKee, BMHC, SB11, File 2, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1949.
389. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):50.
390. Elizabeth Bixler, "Psychiatric Nursing in the Basic Curriculum", *Mental Hygiene* (Jan 1948):89-101.
391. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):50.
392. Ibid. There were no applicants for the mental nurse diploma program in 1952.
393. Ibid.
394. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Minister Schultz from Marion Lindeburgh, Director of School for Graduate Nurses, McGill University, May 27, 1946. Schultz was told post-graduate students needed an RN for admission.
395. WGH Alumnae Archives, Box 6, Annual Reports, WGH, 1951, 80.
396. Ibid.
397. PAM, S-16-19-1, Off-Site, Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Letter to Civil Service Commission from Acting Deputy Minister, Health, Aug 25, 1948.
398. Ibid.
399. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Memo for file (Ivan Schultz), May 11, 1949.

400. McKee, BMHC, SB11, File 2, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1949.
401. McKee, BHMC, SB17, no file name, Newspaper clipping dated 1949, "Mental Hospital Graduation Exercises Attended by Large Crowd in First United Church".
402. Ibid. Also see PAM, G1262, GR1551, Health and Welfare Minister's Office Files, Papers re-Administration and Nursing, Progress Report, Dr. T. Pincock, Oct 11, 1949. Mental health grants were part of the Dominion health grants.
403. PAM, RG18, A4, Box 12, Public Works, File 1921-23, Brandon Nurses' Home, Memo to the Minister from Oxton, Deputy, Dec 7, 1921. Oxton cited Baragar's vision of eliminating attendants and having only trained nurses and orderlies at the hospital.
404. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947. Elsie Ogilvie gathered information about the Brandon attendant training program in spring, 1947. The certificate was different than the diploma in mental nursing.
405. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1940,3. Also see "Annual Report", 1944,4.
406. McKee, BMHC, SB6, File 1, Julia Ryfa, "Message to Students", *The Ego* (1952-3):50; McKee, BMHC, SB11, File 2, Calendars, Brandon Hospital for Mental Diseases, School of Nursing, Calendar, 1949.
407. PAM, S-16-19-1, Off-Site, Temp. Box 34, Health and Welfare Minister's Office Files, Notes as taken at Law Amendments, April 13, 1948. Barnett was the spokesperson. Also see A. Osted, "40th Anniversary, A Tribute", *Update* (March 2000):3-4. Barnett, originally from Wales, was an attendant at the Ontario Hospital, Kingston before joining the Selkirk Hospital for Mental Diseases in 1935 as an attendant. He was the founder and first president of the Psychiatric Nurses Association of Manitoba.
408. PAM, S-16-19-1, Off-Site, Temp. Box 34, Health and Welfare Minister's Office Files, Letter from Ivan Schultz to Hon. S. Garson, Jan 2, 1948.
409. PAM, S-16-19-1, Off-Site, Temp. Box 34, Health and Welfare Minister's Office Files, Letter to I. Schultz from Dr. Pincock, April 15, 1948. Pincock also mentioned nurses but the nursing staff at Brandon were not involved at this time. There may have been nurse involvement at the other mental hospitals.
410. APA, Nursing, Site Visits, Box 13, File 264, Winnipeg Psychopathic Hospital, Report of Accredited Nursing School, April 20, 1948. Visit by Lela Anderson.
411. Margarita Silver (nee Homesen), tape-recorded interview by writer, Winnipeg, Manitoba, Aug 28, 1999.
412. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Report on Psychiatric Services, Dr. T. Pincock, 1949.
413. NAC, RG29, Vol. 331, File 436-1-6, Mental Health Division, Letter from E. MacKenzie, Acting Superintendent of Nurses, Brandon Hospital for Mental Diseases to Dr. S. Schultz, Oct 25, 1949. The letter outlined all courses taught with lists of needed resources.
414. SAB, SRNA, R-1271, 54, Council Minutes, Meeting May 19, 1949. About 100 students per year affiliated to the Munroe Wing but not to the mental hospitals.
415. PAM, GR157, H-14-21-1A, Off-Site, Student Nurses, 1945-57, "A Short History of the First Year Qualifying Examinations in Manitoba", was sent to Ivan Schultz Nov 22, 1945 in preparation for a meeting which some board members were to have with

him. The history explained qualifying examinations arose out of Hall's findings, and listed same. Also see WGH Alumnae Archives, Journal Collection, Gertrude Hall, "MARN Annual Meeting", *The Canadian Nurse* (June 1940):366-367. Hall's report itself was never found.

416. MARN Archives, 47-24-058, Annual Meeting Report, 1948,14.

417. PAM, GR157, H-14-21-1A, Off-Site, Student Nurses, 1945-57, "A Short History of the First Year Qualifying Examinations in Manitoba", was sent to Ivan Schultz Nov 22, 1945 in preparation for a meeting which some board members were to have with him. The history explained qualifying examinations arose out of Hall's findings, and listed same. Also see WGH Alumnae Archives, Journal Collection, Gertrude Hall, "MARN Annual Meeting", *The Canadian Nurse* (June 1940):366-367.

418. Ibid.

419. WGH Alumni Archives, Curricula, "Minimum Standards and Recommendations for Manitoba Schools of Nursing", MARN, 1941.

420. MARN Archives, 47-24-058, General Meetings, May 30, 1940.

421. MARN Archives, 47-24-058, Board Meeting Minutes, Dec 11, 1947. Wedderburn's letter was read to Board members and referred to the superintendents of training schools committee.

422. MARN Archives, 47-24-058, Board Meeting Minutes, March 30, 1948.

423. WGH Alumni Archives, Curricula, "Minimum Curriculum and Standards for Schools of Nursing in Manitoba", MARN, 1949. With 900 student nurses in Manitoba only about 10% received the affiliation. (WGH, 80 and a handful from the Grace and Brandon General).

424. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from D. McKerracher, June 18, 1947. McKerracher decided on his own training program and told Ellis there was no accommodation for general students.

425. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Brandon. Briefing notes from Dr. S. Schultz to his brother Ivan Schultz re-W. Metcalfe article, April 6, 1949.

426. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Letter from Dr. Pincock to Dr. Jackson, Deputy Minister of Health, July 2, 1948.

427. Ibid. Elsie Ogilvie's *Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada* was discussed at the meeting. Ogilvie promoted psychiatric affiliations for general hospital students. See NAC, RG29, Vol. 1418, Health & Welfare, Mental Health Subcommittee on Training, Minutes, June 28, 1948.

428. MARN Archives, 47-24-058, Board Meeting Minutes, Oct 7, 1947. The Board was notified that Wedderburn met with the executive secretary around the lack of registered nurses in psychiatry. This was in addition to her letter. She was trying to "wake up" the MARN.

429. McKee, BMHC, SB17, File: Graduations to 1948; WGH Alumnae Archives, Yearbooks, *Blue and White*, 1945-1950.

430. Silver interview.

431. Ibid.

432. Madeline Whyte (nee Mercier), tape-recorded interview by writer, Selkirk, MB, Sept 9, 1999; Catherine Dennis, tape-recorded interview by writer, Brandon, MB, Aug

30, 1999.
433. McKee, BMHC, SB17, File: Graduation Programs.
434. Ibid. For example, Rogalsky, Scherza, Kalakailo.
435. Whyte interview; Silver interview.
436. Silver interview.
437. Whyte interview; Jessie Little (nee Murison), tape-recorded interview by writer, Brandon, MB, Aug 30, 1999.
438. Whyte interview; For a discussion on nurses' residences see Dianne Dodd, "Nurses' Residences: Using the Built Environment as Evidence", *Nursing History Review* 9 (2001): 185-206.
439. Barbara Marshall (nee McKay), tape-recorded interview by writer, Brandon, MB, Aug 30, 1999; Jeanette Young (nee Higgs), tape recorded interview by writer, Aug 23, 1999.
440. Young interview.
441. Little interview; Marshall interview.
442. Whyte interview; Silver interview; Marshall interview.
443. Young interview.
444. Silver interview; Whyte interview; Little interview; Young interview. Silver brought her copy to the interview.
445. Young interview.
446. Whyte interview.
447. Silver interview.
448. Little interview; Young interview.
449. Marshall interview.
450. Dennis interview.
451. Silver interview; Whyte interview.
452. Young interview.
453. Whyte interview; Dennis interview.
454. Silver interview; Whyte interview.
455. Silver interview.
456. Silver interview; Whyte interview; Young interview. These three graduates each asked the interviewer if anyone had discussed this patient.
457. Silver interview; Whyte interview.
458. Silver interview.
459. Whyte interview.
460. Little interview.
461. Silver interview.
462. Whyte interview; Young interview.
463. Silver interview.
464. Whyte interview; Young interview.
465. Silver interview.
466. Whyte interview; Young interview; Little interview.
467. Marshall interview.
468. Whyte interview; Young interview.
469. Little interview; Silver interview.
470. Young interview; Little interview; Whyte interview. At an earlier interview,

Young reported that she felt like a "foreigner" while at the WGH. See PAM, C-1769-98. Jean Young, Interview with Kathryn McPherson, May, 1990.

471. Ibid.

472. Young interview; Silver interview.

473. Silver interview.

474. Young interview.

475. Whyte interview; Little interview.

476. Silver interview.

477. Silver interview; Whyte interview.

478. Whyte interview.

479. Young interview.

480. Silver interview.

481. Little interview.

482. AHCPMH, Ontario Hospital, Hamilton, Copy of a speech given by Dr. C. Hincks to Council of Social Agencies, Hamilton, "Mental Health Resources", Feb 13, 1946.

483. AO, RG10-107-0-436, HS22-1, Inspection Reports, Hamilton, May 7-11, 1945. Also see memo from Miss Munn, Director of Nurse Registration, Ontario to training schools, Nov 12, 1945. Munn tried to recruit graduating students from around the province to join the mental hospitals' staffs.

484. Ibid.

485. AO, RG10-107-0-172, Container 24, Nurses, 18-7-3, 1945, Memo from Dr. J. Phair to Dr. R. Montgomery, Director, Hospitals re-student nurses, May 22, 1945.

486. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Letter to Dr. C. Fitzpatrick, Chairman of Committee on Psychiatric Nursing, APA, from Dr. B. McGhie, Deputy Minister, April 8, 1943.

487. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, "Survey of Nursing in the Ontario Hospitals", Spring 1943.

488. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Memo to file, McGhie, May 3, 1943.

489. SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from McKerracher, June 18, 1947.

490. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Memo from Dr. Clark to Dr. McGhie, Oct 25, 1943.

491. Ibid.

492. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Memo from Dr. Clark to Dr. McGhie, March 29, 1944. Clark did not include the name of the superintendent on this summary so perhaps it was sent anonymously.

493. Ibid.

494. Ibid. Dr. D. Fletcher, Medical Superintendent of the Ontario Hospital, Whitby was the writer.

495. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Memo from Dr. Stevenson to Dr. Clark, March 7, 1944.

496. AO, RG10-20-A-1, File 1.1, Superintendents' Conferences, Minutes, 1930-49, Meeting June 28, 29, 1944. The doctors believed that six schools were still required. The Orillia training school ended prior to the June meeting.

497. Ibid.
498. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Letter from Dr. McGhie to Fitzsimmons, May 23, 1944. She was told the committee's report was completed but did not send it to her. His letter contained a "white lie" re-same.
499. AO, RG10-107-0-172, Container 24, Nurses, 18-7-3, 1945, Memo from Dr. J. Phair to Dr. R. Montgomery, Director, Hospitals re-student nurses, May 22, 1945; AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, Memo from Dr. Clark to Dr. McGhie, Oct 25, 1943.
500. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Oct 12, 1945; APA Archives, Nursing, Site Visits, Box 12, File 240, Ontario Hospital, Hamilton, Report of Accredited Nursing School, 1947.
501. AO, RG10-107-0-172, Container 24, Nurses, 18-7-3, 1945, Memo from Dr. Montgomery, Director of Hospitals to all medical superintendents re-RN shortage, Dec 7, 1945; RG10-20-A-1, File 1.2 Minutes of Superintendents' Conferences, 1945-49, Oct 12, 1945. Salaries paid at the mental hospitals were not keeping up with the general hospitals.
502. AO, RG10-107-0-172, Container 24, Nurses, 18-7-3, 1945, Memo from Dr. Phair, Deputy to Mr. Foster, Civil Service, Sept 8, 1945.
503. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Oct 12, 1945.
504. Ibid.
505. AO, RG10-107-0-172, Container 24, Nurses, 18-7-3, 1945, Memo from Dr. Montgomery to superintendents, Dec 7, 1945.
506. RNAO Archives, Green Books, Minutes, 1944-45, Sept 30, 1944, Board of Directors meeting. In June 1944 Smith and her colleagues met with Laura Fitzsimmons, so Fitzsimmons most likely inspired Smith to advocate.
507. Ibid.
508. RNAO Archives, Green Books, Minutes, 1944-45, Annual Meeting, April 12-14, 1945.
509. WGH Alumnae Archives, Journal Collection, George Stevenson, "The Place of Mental Hygiene and Mental Nursing in this Reconstruction Period", *The Canadian Nurse* (July 1945):519-522.
510. WGH Alumnae Archives, Journal Collection, Laura Fitzsimmons, "Mental Hygiene and Hospital Nursing", *The Canadian Nurse* (July 1945):523-526.
511. WGH Alumnae Archives, Journal Collection, Hilda Bennet, "Preparation for Psychiatric Nursing", *The Canadian Nurse* (July 1945): 539-541.
512. WGH Alumnae Archives, Journal Collection, Editor, "Reader's Guide", *The Canadian Nurse* (July, 1945):504.
513. WGH Alumnae Archives, Journal Collection, Dorothy Riddell, "Affiliation for Student Nurses in Psychiatry", *The Canadian Nurse* (Feb 1946):138; Ella Smith, "Psychiatric Affiliation", *The Canadian Nurse* (Feb 1947):114-117.
514. CNO Archives, Council of Nurse Education, Report to RNAO, 1947.
515. Ibid.
516. AO, RG10-107-0-173, Container 24, Nurses, 18-7-3, 1946, Letter from Rice-Jones to J. Phair, June 11, 1946. Letter to Rice-Jones from Dr. J. Phair, June 15, 1946.
517. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting April 18, 1947; RG10-107-0-174, Container 24, Nurses, 18-7-3 1947, Meeting

July 10, 1947, Dr. Montgomery to special committee.
518. Ibid.
519. AO, RG10-107-0-173, Container 24, Nurses, 18-7-3, 1946, Memo from Dr. Fletcher, Whitby to Dr. Montgomery, Director of Hospitals, April 29, 1946.
520. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Memo from Dr. Senn, Hamilton to Dr. Montgomery, Director, March 24, 1947.
521. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting April 18, 1947.
522. Ibid.
523. Ibid.
524. Ibid.
525. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.
526. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Meeting July 10, 1947 with special committee and Dr. Montgomery.
527. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.
528. Ibid.
529. AO, RG10-107-0-173, Container 24, Nurses, 18-7-3, 1946, Health Minister Russell Kelley wrote a memo to his file re-a 9 month course for nurses' aides, similar to RNAO course, July 15, 1946. The minister and his deputy communicated with one another that such a plan made more sense than starting a new two-year course. See memo July 22, 1946. Also see RG10-107-0-176, Container 24, Nurses, 18-7-3, 1949, Memo from Montgomery to Hon. R. Kelley, Nov 9, 1949.
530. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.
531. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Meeting July 10, 1947 with special committee and Dr. Montgomery. Fair was a graduate of the Ontario Hospital, Whitby.
532. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Memo from Dr. Montgomery to Hon. Kelley, Minister, Oct 7, 1947.
533. CNO Archives, Council of Nurse Education, Report to RNAO, 1947. Esther Rothery placed the general affiliation in second year and then it moved back to third year during the war. See AO, RG10-107-0-162, Nurses, Affiliation Courses, Memo from Dr. Montgomery to Superintendents, June 17, 1947.
534. AO, RG10-107-0-162, Nurses, Affiliation Courses, Memo to Dr. Montgomery from Dorothy Riddell, Inspector, March 24, 1947; RG10-107-0-175, Container 24, Nurses, 18-7-3, 1948, Letter to Grace Fairley from E. Dick, Feb 20, 1948.
535. CNO Archives, Council of Nurse Education, Book 3, Minutes, June 17, 1948; RNAO Archives, Box 33, Curriculum for Schools of Nursing in Ontario, 1949, 10.
536. Ibid.
537. AO, RG10-107-0-175, Container 24, Nurses, 18-7-3, 1948, Letter to Grace Fairley from Edith Dick, Feb 20, 1948; CNO Archives, Council of Nurse Education,

Report to RNAO, 1950.
538. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting, May 6, 1949.
539. Ibid.
540. Ibid.
541. AO, RG10-107-0-175, Container 24, Nurses, 18-7-3, 1948, Letter to Grace Fairley, BC From Edith Dick, Director of Nurse Registration, Feb 20, 1948. Dick noted this was about 400 students a year.
542. CNO Archives, Council of Nurse Education, Book 3, Minutes, June 17, 1948.
543. Hamilton Psychiatric Hospital Archives, Nurses, School of Nursing, Affiliations, 1948-1950. Because the residence was small the affiliation program was limited re-student numbers.
544. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Memo from Dr. Phair, Deputy to Hon. Russell Kelley, Minister, re-students, July 30, 1947.
545. Ibid; Also see Memo from Russell Kelley, Minister, to Dr. Phair, Aug 7, 1947.
546. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Memo from Dr. Senn to Dr. Buck re-campaign, Aug 1, 1947. Senn had no response in the large daily newspapers.
547. AO, RG10-107-0-175, Container 24, Nurses, 18-7-3, 1948, Memo from Laura Fair to superintendents of nurses re-recruitment, April 10, 1948. Brochure attached.
548. AO, RG10-107-0-176, Container 24, Nurses, 18-7-3, 1949, Memo from Dr. Buck to medical and nursing superintendents, Aug 25, 1949.
549. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Nov 25, 1949.
550. AO, RG10-107-0-183, Container 25, Male Nurses, 18-7-5, 1949, Memo from Phair to Hon. R. Kelley, March 29, 1949.
551. RNAO Archives, Green Books, Minutes, 1946-47, June 20, 1947 Board meeting. Report presented to directors.
552. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Letter to Hon. Paul Martin, Ottawa, from R. Kelley, March 8, 1947.
553. AO, RG10-107-0-173, Container 24, Nurses, 18-7-3, 1946, Press release, May 29, 1946.
554. AO, RG10-107-0-173, Container 24, Nurses, 18-7-3, 1946, Memo to file re-9 month course, R. Kelley.
555. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Letter to Paul Martin from R. Kelley, Feb 16, 1947. For information about the federal grant to the CNA see Richardson, "Lively Combat".
556. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Letter to R. Kelley from Paul Martin, March 12, 1947.
557. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.
558. AO, RG10-107-0-176, Container 24, Nurses, 18-7-3, 1949, Memo from Montgomery to Hon. R. Kelley, Nov 7, 1949.
559. AO, RG10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Letter to Paul Martin from R. Kelley, Feb 16, 1947. The Dominion-Provincial Health Grants announced in

1948 had no impact until the next decade.
560. AO, RG10-107-0-175, Container 24, Nurses, 18-7-3, 1948, Letter to Grace Fairley, BC From Edith Dick, Director of Nurse Registration, Feb 20, 1948.
561. CNO Archives, Council of Nurse Education, Report from Senior Inspector, Dorothy Riddell, 1955.
562. Simmons, *Unbalanced: Mental Health Policy in Ontario*, 1,8. Simmons cited an anonymous psychiatrist who believed that mental hospitals attracted authoritarian individuals. Also see Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 244-46. Grob points out that medical superintendents held little status among their medical colleagues. To compensate, they tightened their authority within their hospitals and exerted their authority in all non-medical relationships, for example with governments, nurses and so forth.
563. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.
564. NAC, RG29, Vol. 336, File 435-5-5 pt.1, Mental Health Division, Nursing, Letter to E. Ogilvie from Edith Dick, Assistant Director, March 27, 1947.
565. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947; RG29, Vol. 335, File 436-5-5, pt.1, Mental Health Division, Nursing, Letter to Dr. Montgomery from E. Ogilvie, Aug 19, 1948.
566. RNAO Archives, Green Books, Minutes, 1950-51, Dec 15, 1950 Board meeting. Letter was read.
567. Ibid. It was apparent from the minutes that the Board was aware of Saskatchewan's new association but unaware of a similar group then in British Columbia. The Alberta association had no legislation. See AO, RG-10-107-0-174, Container 24, Nurses, 18-7-3, 1947, Letter from Mr. R. Strong, Psychiatric Nurses Association, BC to L. Fair, Oct 24, 1947.
568. Ibid.
569. SAB, SRNA, R-993, 39F (3.2-8-2), Letter to K. Ellis from E. Howard, School of Nursing, University of Toronto, March 13, 1950. Howard wanted information about the new nursing profession in Saskatchewan.
570. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947.
571. APA Archives, Nursing, Site Visits, Box 12, File 240, Ontario Hospital, Hamilton, Report of Accredited Nursing School, 1947; AO, RG10-107-0-435, HS-22-1, Hospital Inspections, Hamilton, 1948.
572. Ibid.
573. Hamilton Psychiatric Hospital Archives, School of Nursing, Administration Records (basement filing cabinet), Student files, 1940-1949.
574. Annie Smith (nee Galuska), tape-recorded interview by writer, Hamilton, ON, Oct 26, 1999; Irene Wilson (nee Haverty), tape-recorded interview by writer, Hamilton, ON, June 21, 1999.
575. Smith interview.
576. Hamilton Psychiatric Hospital Archives, School of Nursing, Administration Records (basement filing cabinet), Student files, 1940-1949.

577. Wilson interview.
578. Dorothy Mulder (nee Campbell), tape-recorded interview by writer, Winnipeg, MB, Sept 6, 1999. Mulder graduated from the North Battleford program and immediately applied to the Ontario Hospital, Hamilton so that she could obtain an RN diploma.
579. Smith interview.
580. Joyce Costley (nee Tournay), tape-recorded interview by writer, Hamilton, ON, June 22, 1999.
581. Ibid.
582. Ibid.
583. Wilson interview.
584. Smith interview.
585. Costley interview; Smith interview.
586. Costley interview. With their last names difficult to tell apart, Costley also related lots of mix-ups over her 3 years.
587. Wilson interview.
588. Mulder interview.
589. Smith interview; Costley interview; Wilson interview.
590. Mulder interview. She lost one year of school.
591. Mulder interview.
592. Smith interview.
593. Costley interview.
594. Smith interview.
595. Mulder interview.
596. Ibid.
597. Smith interview; Costley interview; Wilson interview.
598. Smith interview; Mulder interview.
599. Wilson interview.
600. Mulder interview.
601. Smith interview.
602. Costley interview.
603. Mulder interview; Wilson interview.
604. Wilson interview.
605. Ibid.
606. Smith interview.
607. Mulder interview; Costley interview.
608. Wilson interview.
609. Smith interview.
610. Ibid.
611. Ibid.
612. Wilson interview; Mulder interview.
613. Costley interview.
614 Peter Nolan, "Psychiatric Nursing, Past and Present: The Nurses Viewpoint" (Ph.D. diss., University of Bath, UK, 1989).
615. Ibid., 187-208.
616. Ibid., 197.
617. Ibid., 195.

618. Olga Church, "That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963" (Ph.D. diss., University of Illinois, 1982).
619. Ibid., 197-200. Whether it was mental or general training many women were rejecting unfavourable conditions. These 32 schools were just ones that offered the combined course.
620. Ibid., 191.
621. Ibid., 200-225. The APA's Committee on Psychiatric Nursing continued to participate in accreditation of mental hospital schools because of a concern from psychiatrists that if the NLNE took over, some schools would lose accreditation.
622. Ibid., 191.
623. Church, 192-193. Veterans' hospitals' psychiatric wards were utilized for student experiences. In Canada the Canadian Government offered grants through the CNA to schools for recruitment purposes but this did not influence psychiatric affiliations.
624. Ibid., 194. The affiliation was not offered to all students of these schools. Six states mandated psychiatric affiliations by the end of the decade but the NLNE did not, mostly because of a shortage of nurse instructors with psychiatric nursing expertise.
625. Ibid., 198-200.
626. Kathryn McPherson, *Bedside Matters. The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), 205-213.
627. Ibid., 209-211.
628. Ibid., 205-219.
629. Dianne Dodd, "Nurses Residences: Using the Built Environment as Evidence", *Nursing History Review* 9 (2001):185-206. Residences were a focal point.
630. McPherson, 187-197, 216-219; Janet Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta, 1859-1996* (Vancouver: UBC/UofA Press, 1998), 631.
631. Nolan, 211-213.
632. Ibid., 214-217.
633. Ibid., 217-218.
634. Ibid., 214.

Chapter 6

Critical Years: The Battle for Control of Canadian Education for Psychiatric Nursing, 1947-1955

Introduction

The years between 1947 and 1955 were critical ones in the development of education for psychiatric nursing. For the first time the issue became a subject of debate on the national scene, where Canadian nurses battled with medical psychiatry and the federal government for the "prize", the control of education for psychiatric nursing. This chapter shows that nursing came dangerously close to losing all control over education for psychiatric nursing as well as losing the specialty.

This chapter establishes the turning point in the battle and outlines the effects of the struggle on the development of Canadian psychiatric nursing. It shows that nurse leaders determined that the solutions arrived at by psychiatrists for the separate and distinct education of psychiatric nurses in Saskatchewan, Alberta and British Columbia were not appropriate for the whole country. This chapter argues that Canada's nursing leadership thwarted the attempt by Western Canadian psychiatrists to extend their monopoly over psychiatric nursing education eastward. And most significantly, this chapter shows how the provision of education for psychiatric nursing in Canada split along provincial boundaries into two models.

A Problem of National Importance

With mentally ill patients occupying forty-six percent of all hospital beds in Canada at the end of World War II, desperate provincial deputy health ministers passed a resolution urging the federal Health and Welfare Department to create a mental health division.[1] The war effort had exposed a high rejection rate for the young men who were attempting to join the armed forces and the federal government too was concerned with its citizens' mental health status.[2] The Mental Health Division became a reality with the appointment of psychiatrist Dr. Charles Stogdill as Director. Rather than an administrative function, the new division's mandate was to provide leadership and consultation to the provinces around mental health policy and research.[3] To that end the Advisory Committee on Mental Health was established by an order-in-council, with its fifteen appointees consisting of the provincial mental health directors and five university professors of psychiatry.[4] The post-war power and influence held by medical psychiatry at the provincial level took root federally and grew even stronger with the announcement of the National Health Grants Program in 1948.[5] Of the set of ten grants to the provinces for improving health services, the mental health grant was the largest, initially set at four million dollars per year.[6] Although Dr. Stogdill was optimistic that the mental health grant would improve psychiatric care at the provincial level, his colleague, Elsie Ogilvie, had just completed a federal survey of mental hospital nursing, and with her report in hand, Stogdill noted that "the greatest obstacle to expansion with the grant is the lack of trained mental hospital nurses".[7]

The Federal Government's Mental Hospital Nursing Survey

One of the first projects of the new Mental Health Division was requested by the provincial mental health directors, who wanted a picture of the mental hospital nursing situation from province to province, and advice as to how to ameliorate the chronic shortage of mental hospital nurses.[8] Elsie Ogilvie was hired by the national Health and Welfare Department as a consultant in psychiatric nursing to carry out the survey. She was a graduate of the McGill University School of Nursing and had spent most of her career in psychiatric nursing administrative positions in New York State and Connecticut. Although hers was a temporary position, Ogilvie was one of the first nurse consultants hired by the Health and Welfare Department.[9]

Ogilvie collected data over a six-month period in 1947 by visiting thirty-six Canadian mental hospitals, three general hospital psychiatric units and three veterans' hospitals' psychiatric wards. Along the way she conferred with superintendents of nurses and developed a detailed report for each province. The report included:

Findings

There are 50,000 patients in the facilities visited.
The nursing shortage has become acute with only 500 RNs employed, a drop of 300 since the end of the war.
A yearly average of 465 general hospital student nurses receive a psychiatric affiliation.
Twenty-five percent of all schools of nursing send some or all students on a psychiatric affiliation.
Eleven mental hospitals offer combined mental and general nursing programs with an average total enrolment of 240 students.
Combined programs are located in Nova Scotia, Quebec, Ontario, Brandon and Ponoka. They are one year longer in the west.
Mental hospital traditions means some superintendents of nurses have little input into the education program.
Male patients are not receiving quality nursing care in many hospitals.

Recommendations

1. Improve residences, classrooms and school libraries.

2. Minimum provincial curricula needs to include a required psychiatric affiliation.
3. Offer more university courses to prepare nurses for the specialty, especially in teaching and administration.
4. All 11 combined programs need to be the same length, for example three years because four years is a financial hardship for students.
5. The 11 combined schools to be continued for about ten years, or until all general students receive the psychiatric affiliation.
6. Conduct ongoing recruitment of students to the combined schools.
7. Superintendents of nurses to be given authority over all nursing departments and schools.
8. Attendants and ward aides need a standardized three to six month training course at employment.[10]

Ogilvie clearly favoured increasing the registered nurse component of the mental hospitals' staff, both through the combined courses and by means of increased affiliations. While she recommended short courses for psychiatric hospital aides she did not support separate mental hospital nurse training programs and later referred to them as "half-baked courses put together for "psychiatric nurses" without any general preparation".[11] Though the federal survey was carried out five years after Laura Fitzsimmons' work in Ontario, its recommendations were similar.[12]

The reactions from the provincial directors of mental health were predictable and reflected the status of psychiatric nurse training within their provinces. Ontario's Dr. R. Montgomery passed the report directly to Laura Fair, the province's new Supervisor of Nurses for the Ontario Hospitals and the person responsible for coordinating mental hospital affiliations for general students.[13] Dr. Pincock, Manitoba's Chief Provincial Psychiatrist, was pleased with Ogilvie's excellent assessment of the combined training program at the Brandon Hospital for Mental Diseases and was eager to arrange more psychiatric affiliations for his province's student nurses.[14] However, typical of the longstanding lack of coordination of psychiatric nurse training in Manitoba, Pincock did

not pass a copy of the report to Elva Cranna, Superintendent of Nurses at the Brandon facility. Cranna requested a copy from Ogilvie.[15] Saskatchewan's new Commissioner of Mental Health Services, Dr. Donald McKerracher, was perturbed that Ogilvie had not recognized the Saskatchewan training program as anything more than attendant training, and argued that mental hospital students did not require any general nurse training.[16] McKerracher did not share the report with any nurses in Saskatchewan and instead directed it to Dr. Sam Lawson, Medical Superintendent at the Weyburn Mental Hospital and the person responsible for designing the new three-year training curriculum. Lawson's sarcastic letter to Ogilvie about her assessment revealed his anger:

> We have not yet obtained a superintendent of nurses but for some reason or the other, which I am sure would be hard for you to understand, the hospitals are still functioning, but I suppose, as you suggest, at a low level. At the moment we are negotiating with the attendants' union and the position of Registered Nurse is a touchy one.[17]

Ogilvie's recommendations had implications for general nursing and nursing curricula but her report was not shared officially with the CNA or provincial nurses' associations. Olive Griffith, an instructor at the University of Toronto's School of Nursing, made a special request to Dr. Stogdill for a copy but was advised that the data were confidential to the federal and provincial governments.[18] Ogilvie shared her findings in letters to those who requested information on the survey; and as Laura Fitzsimmons had done before her, published an article in *The Canadian Nurse*. In it she highlighted some striking statistical data from the survey and asked "What is Canadian nursing doing to meet this challenge?" She believed that psychiatric nursing's development hinged on affiliations and she warned her colleagues "not to be dilatory in developing more psychiatric affiliations".[19]

For the remainder of her contract with the Mental Health Division, Ogilvie communicated and met with superintendents of nurses and provincial mental health directors and provided them with resources. Sometimes it was as simple as suggesting a psychiatric nursing textbook and at other times she recruited nurse administrators and instructors for mental hospitals and schools of nursing.[20] In conjunction with the CNA she developed a brochure on psychiatric nursing which focused on post-graduate education and recruitment to the specialty, and with the National Health Grants Program announcement close at hand, she organized resources for post-graduate psychiatric nursing education.[21] She communicated with Lucille Petry, Chief Nurse Officer with the United States Public Health Service, about the stipends awarded to nurses and grants to universities under the National Mental Health Act in that country. In the United States, grants were provided to university schools of nursing to develop full graduate programs in psychiatric nursing.[22] Ogilvie believed that the preparation of well-qualified specialists was an important first step in developing Canadian psychiatric nursing. She contemplated the idea of university programs in advanced psychiatric nursing education and student scholarships to encourage leadership in the specialty.[23] Dr. Stogdill and some of the provincial directors of mental health believed that Ogilvie was providing much needed psychiatric nursing leadership, and lobbied Deputy Health and Welfare Minister Dr. G. Cameron to make the psychiatric nursing consultant position permanent. Cameron promised the psychiatrists that he would "talk to the boss" (Paul Martin) and in the meantime Ogilvie joined the faculty at the McGill University School for Graduate Nurses.[24] For over two years Stogdill, Cameron and Martin exchanged numerous memos and proposals around the nurse consultant position. Stogdill wrote:

> The Dominion Government has assured the Canadian Nurses' Association that it will give all possible help in the existing critical shortage of nurses. This shortage exists most markedly at the mental hospitals. It is necessary to have in this Division technical assistance on nursing matters to carry out its function. It will contribute greatly to the recovery rate of mental hospital patients to have improved nurse and attendant training programmes. Many of the provinces feel this need but the expert guidance is not available. Every province spends more money on the mentally ill than on any other health endeavour. It is submitted that the appointment of a nurse as Consultant in Mental Health would be much appreciated by the nursing profession as she would help in recruitment. Under the Chief of Mental Health the duties would be:
> 1. To provide leadership in psychiatric nursing for Canada.
> 2. To prepare professional information, educational resources and statistics.
> 3. To develop standards for mental hospital staffing.
> 4. To assist in the preparation and conduct of training courses for nurses and aides in mental hospitals and training schools.[25]

Though the proposed annual salary of $3,600-$4,380 was not an issue, Health and Welfare Minister Paul Martin initially was concerned that "we are taking over a provincial function", but he was reassured by Cameron that the provinces were desperately requesting this assistance from the federal government. Cameron advised Martin that Stogdill was perturbed with the delays and was threatening to leave his own position in protest.[26] Martin gave in and in his submission to the Treasury Board argued that the benefits outweighed any risks to government. He pointed out that Canada was falling behind the United States in resources for mental health care.[27] It is not known at what point in the process the submission was halted–"cancelled" was handwritten on Martin's document and the position was not made permanent.[28]

Upon reviewing Ogilvie's survey several years later, a perceptive Dorothy Percy inquired: "By the way, how did we let Miss Ogilvie slip away from us?"[29] How indeed? There was no evidence to suggest it was anything more than a bad Treasury Board decision, but it could have been that Martin did not ever submit the request. He initially

had been ambivalent. Or perhaps someone else influenced his thinking. Dr. McKerracher did not like what Ogilvie wrote in her report about the Saskatchewan training schools, or her focus on educating registered nurses for mental hospital care.[30] With the proposal for the nursing consultant position gaining support from his colleagues on the Advisory Committee on Mental Health, he could easily have opposed the idea in discussions with Martin or Cameron. His mission, after all, was to have other jurisdictions adopt this new three-year training program.[31] Or perhaps Martin and Cameron decided that a mental health nursing consultant was not as much a priority as hiring a general nursing consultant. The RNAO, CNA and provincial deputy ministers of health had been lobbying for such a position at the same time that the Treasury Board submission was cancelled.[32] Until 1947, consultant positions in federal health care traditionally had been held by physicians and placing two nurses in consultant positions might have been considered too groundbreaking.[33]

The shortage of trained nurses was the priority problem facing Canada's mental hospitals; and since discharging hospitalized patients was dependent upon obtaining more nurses,[34] it was paradoxical that the mental health nurse consultant position was not realized. The provincial mental health directors had requested the survey in order to secure help in the face of a nursing shortage in the provincial mental hospitals, and Stogdill and most of these directors perceived that a nurse consultant could help them implement the recommendations. The cancellation of this proposed position brought an end to a brief psychiatric nursing presence within the federal government's Mental Health Division, and the potential to influence and shape Canadian psychiatric nursing's development was lost. In contrast, psychiatric nurses at the federal level in the United

States were playing an active role in shaping mental health policy and psychiatric nursing's development, especially in the area of higher education.[35] Ogilvie's meticulous survey gathered dust. One copy was used by the CNA to support its recommendation to the World Health Organization that Ogilvie should be considered a candidate for international psychiatric nursing consultant work.[36] A few years later Ogilvie took her leadership skills back to the United States and became the American Psychiatric Association's nursing consultant.[37]

Dr. Stogdill was not able to implement any of the survey recommendations because he was the lone health professional in the Mental Health Division. Most of the provincial mental health directors were frustrated with the lack of federal government movement; and while the provinces might have independently implemented some of Ogilvie's recommendations, most did not have registered nurses with the requisite expertise. Further, many of her recommendations were tied to nursing education.

Two years after Ogilvie first presented her report to these psychiatrists a resolution was passed at the Advisory Committee on Mental Health which focused on just one of Ogilvie's recommendations. The doctors were not optimistic about obtaining more registered nurses, and as an interim measure, requested the assistance of a federal psychiatric nurse consultant to develop a standardized curriculum for training psychiatric hospital aides.[38] Dr. McKerracher clarified that he did not want a shorter course than his three-year mental hospital training program because his would then lose value.[39] And Stogdill, who was cautious because of his unsuccessful attempt to obtain a nurse consultant, made it clear that such a nurse could assist each of them to develop an aide training plan, but that the federal government would not impose a training program on the

provinces.[40] However, there was no action on the resolution and within a few months of the advisory meeting and just after he finally received an assistant, Stogdill resigned from the federal government.[41] The next section describes how Stogdill's replacement dealt with the doctors' problem.

The Psychiatrists Ask for Help

Dr. Charles (Chas) Roberts was an ambitious young psychiatrist who moved from his native Newfoundland to join the Mental Health Division, and as he recalled, spent about one hour as Stogdill's assistant before being appointed Director in the summer of 1951.[42] A year into his new position he chaired his first Advisory Committee on Mental Health meeting at which time there was again discussion on the psychiatrists' resolution to engage a psychiatric nurse consultant to help develop a standardized training program for mental hospital aides across Canada.[43] During his first year Roberts had attempted to get a picture of the mental hospital staffing situation in Canada and advised the committee members that "this whole field was too confusing".[44] Without staff resources, he suggested that the provinces instead ought to adopt the popular curriculum for psychiatric aides developed by Laura Fitzsimmons for the American Psychiatric Association and in use at mental hospitals across the United States.[45]

Alberta's Dr. Randall MacLean refused to let the issue drop, however, because he believed that simply adopting the American curriculum would not help solve problems in Alberta. He explained to the committee that male attendants and female psychiatric nurses in Alberta had established a new psychiatric nurses' association and this group was creating tension among some registered nurses.[46] Further, some of his province's

general hospital schools of nursing were refusing to allow their students to affiliate to the mental hospitals because nursing instructors did not want students supervised by non-registered psychiatric nurses. MacLean stated: "Now is the time to define the various terms for mental hospital nursing work being used across our provinces".[47] Another resolution was passed "to study the non-registered mental hospital nursing personnel and develop a uniform minimum training program for this group".[48] Roberts advised the psychiatrists that the psychiatric nursing curriculum for general training schools was to be left in the hands of the Canadian Mental Health Association (CMHA). He did not mention the CNA.[49]

Ogilvie's report had emphasized increasing psychiatric nursing education for registered nurses; but without a federal government nurse consultant to lead this endeavour, Roberts was pleased that the CMHA was examining the issue.[50] The CMHA, formerly the CNCMH, had been heavily involved in the development of the psychiatric nursing course for the CNA's *Proposed Curriculum for Schools of Nursing in Canada*.[51] Marjorie Keyes and her medical colleagues at the CMHA traditionally advocated that mental hospitals ought to be staffed with registered nurses, aides and orderlies.[52] More recently Keyes had asked superintendents of nurses in Canadian general hospitals with training schools to distribute surveys about psychiatric nursing to third year students.[53] While it was not known how many third year student nurses received the questionnaire, of the 1,417 who responded, only 1.4% expressed an interest in pursuing a career in the specialty. Many of the respondents did, however, state positive views about psychiatric nursing.[54] Because of these findings, the scientific planning committee of the CMHA asked Keyes to conduct an in-depth study of psychiatric nursing education offered to

general students and graduate nurses across Canada.[55] Of 102 training schools which received questionnaires, 101 responded. Two provinces had no schools which offered psychiatric nursing affiliations. Thirty-one schools offered no affiliations and minimal psychiatric nursing theory. Seventy-one general hospital schools offered either compulsory or optional affiliations or had psychiatric wards within the home hospital for their students' practical experiences. Fifty of these were located in Ontario. Only five Ontario schools had nothing in place for psychiatric nursing education.[56] Keyes reported:

> In Ontario, compulsory affiliations came into effect in August, 1951 but all undergraduate student nurses are not yet benefiting. The factors that hamper the affiliation are an overreliance on student service by some general hospitals; Ontario Hospitals not conveniently located; a lack of student residences and not enough teachers prepared to instruct psychiatric nursing at the Ontario Hospitals.[57]

The reasons which Keyes identified as hampering affiliations in Ontario were the same across most provinces. She noted that a lack of psychiatric wards at most general hospitals was a problem because it was a complicated procedure to arrange affiliations with distant mental hospitals. She elaborated:

> I raise this because recently several general trained graduates have told me they liked being students at our Toronto Psychiatric Hospital (TPH) but when they went to a mental hospital on a field trip they decided they did not want to pursue a career in the psychiatric nursing specialty. A feeling of fear came over some; the wards were overcrowded and the environment and atmosphere was not like the TPH.[58]

Keyes concluded her report with some questions for her colleagues:

> In general the evidence suggests that much more progressive thinking and planning are necessary if psychiatric nursing is to play its part and an appropriate number of nurses are to choose this nursing specialty. My questions to you: Should this affiliation be made compulsory as it is in Ontario? Should the new program for training "psychiatric nurses" in Saskatchewan be advocated for the rest of the provinces? Should the present study be continued with the aim of collaboration with the CNA in establishing standards?[59]

At the presentation of her report to the scientific planning committee of the CMHA, members centered their discussion on the differences between Ontario and the other provinces in the development of psychiatric affiliations. Although Keyes had been invited to Saskatchewan by McKerracher to view his new program, committee members were not interested in that option. She was requested to begin work on a revised twelve-week affiliation course and to consult with Elsie Ogilvie, who by then had moved into her new consultant position with the APA in the United States.[60] Committee members passed this resolution:

> The Scientific Planning Committee of the CMHA favours a three month affiliation for all undergraduate nursing students in an accredited psychiatric facility. That this affiliation be started on the principle that as many students as possible receive three months and working towards the goal of compulsory affiliations for all.[61]

Keyes met with CNA Executive Committee members who without any discussion, endorsed the CMHA resolution and distributed it to all provincial nurses' associations.[62]

The evidence revealed that Canadian psychiatrists, both those on the federal government's Mental Health Advisory Committee and those on the CMHA's scientific planning committee, spent much time and energy on concerns related to the shortage and training of mental hospital nurses. Medical superintendents had always controlled mental hospital nurse training at their institutions and that tradition continued among Canada's psychiatric elite at the national level. The CNA was neither engaged in the problem or considered a key player. As described next, the national association was forced to deal with psychiatric nursing issues arising in Western Canada.

Canadian Nurses Discover Education for Psychiatric Nursing

On two occasions following the end of the war the CNA highlighted its concerns to the federal government about the shortage of registered nurses working in Canadian mental hospitals. One brief noted "the situation in mental hospitals and sanatoria is nothing short of desperate".[63] However, neither brief was a stand-alone paper about the psychiatric hospital nursing shortage; rather, this information was embedded in the context of the overall post-war shortage of registered nurses. During her federal government tenure Elsie Ogilvie initiated a working relationship with Gertrude Hall, CNA's Executive Secretary, but that link was severed when the psychiatric nurse consultant position ended.[64]

While the psychiatric nursing shortage never made it onto the agenda of the CNA's 1950 biennial meeting in Vancouver, other issues and concerns of the day did. Presentations and discussions focused on the federal government's new health grants to the provinces and their potential impact on the nursing profession, particularly the nursing shortage. Other sessions focused on the need for more nurse aide training programs and nurse retention strategies. One session which received keen attention was a report by Nettie Fidler, who was then interim Director of the Metropolitan School of Nursing in Windsor, Ontario, describing the CNA's new two-year non-service-based demonstration project in nursing education.[65]

Dorothy Percy, Director of the Civil Service Health Division, represented the federal government's Health and Welfare Department at the conference, and her report noted that the 1,000 nurses in attendance were much more from the rank-and-file of Canadian nursing, and not just the leaders, as at past biennial meetings. She believed that

every attendee "generally seemed more mature, professional and knowledgeable about the issues under discussion".[66] Percy mentioned that the nurses continued to lobby the federal government to appoint a permanent nurse consultant within the Health and Welfare Department.[67] Percy, like Elsie Ogilvie, was one of the first registered nurses employed by the Health and Welfare Department and at the time of this meeting was seconded part-time as a nurse consultant. Although her report advised that the nurses at the conference requested her position be made a permanent one, the government did not act upon this for several more years.[68]

Within a few months of the 1950 biennial meeting, the Executive Committee of the CNA was forced to deal with the psychiatric nursing issue. Edith Pullan, Superintendent of Nurses at the Essondale Provincial Mental Hospital in British Columbia, had requested that the Registered Nurses' Association of British Columbia (RNABC) deal with two problems. Pullan noted increasingly strained relations between registered nurses and other non-registered personnel providing mental hospital care in her province. She was also concerned with the wide variation across Canada in the training programs for the non-registered mental hospital group. The RNABC was unable to help Pullan and asked the CNA Executive Committee to intervene.[69] For the first time, committee members learned that the Saskatchewan government had enacted legislation for a psychiatric nurses' association in that province.[70] The issue was referred to the other nine provincial nurses' associations. Feedback from the associations about mental hospital auxiliary training was vague and the Executive Committee decided that it should be pursued at the national level. Hence it had to wait several months for the 1952 biennial meeting.[71]

In the meantime Gertrude Hall, Executive Secretary of the CNA, graciously provided Dr. Roberts and his Mental Health Division with an enormous amount of rich data and a head start on the psychiatric nursing issue. Roberts wrote:

> I am very confused by the terminology used in psychiatric nursing in Canada. To clarify my thinking I will state my conception of the issues and request your personal and official positions.
> 1. The new psychiatric nurse training program in Saskatchewan has many valuable features and is proving useful in that province. Has your association any official views on this new nursing profession?
> 2. Do you consider the RN with a university course in psychiatric nursing to be a psychiatric nurse? She might be confused with the new Saskatchewan psychiatric nurse. Possibly this term should be limited to the RN with further education.
> 3. The RN training schools in mental hospitals seem to be decreasing in number. They exist in Quebec, Ontario, Nova Scotia, Manitoba and Alberta. I feel they should be discontinued but what does your association state?
> 4. What is the position of your association on psychiatric affiliations? I feel they should be three months.
> 5. Does your association have any interest in the psychiatric aide group? I feel a uniform training is desirable.[72]

Roberts was new in his position and the evidence revealed that he had not yet formed definite opinions about psychiatric nursing and was open to feedback. He had visited Saskatchewan and even spent a weekend with Dr. McKerracher and his family but he perceived the new Saskatchewan program as unique to that province.[73] And although there was considerable overlap with the CNA's own project on mental hospital auxiliary training, Hall assured Roberts that "questions of this kind are never any trouble for our office".[74] She explained that she would have to contact all provincial associations for his desired information and developed a questionnaire based on Roberts' queries.[75] It was a large project and better suited to the federal psychiatric nurse consultant position which had been cancelled a few years prior. The following provides a sample of how some of the provincial nurses' associations' directors responded to his questions:

1. Saskatchewan–Their training is adequate for the mental hospitals in the province. Some graduates are seeking employment in general hospitals and the legislation needs to be enforced.
   Manitoba–We do not support a program which creates workers who in Manitoba do not qualify as RNs or LPNs. The trainees who seek work in Manitoba are resentful of their limitations...their prejudices limit their usefulness. Their standards are not acceptable for employment as psychiatric nurses in this province.
   Ontario–Unfavourable, our association recommends the nurse should first be a registered nurse with further education and experience in psychiatric nursing.
   Alberta–We feel that this nurse does not have status and employment is limited to own province.
   British Columbia–The graduate of the new two year course has been given the designation "psychiatric nurse" by Order-in-Council. They will be called licensed psychiatric nurses here. The course is comparable to the practical nurse training program in BC.
   Nova Scotia–We do not approve of the term "psychiatric nurse" to designate the new Saskatchewan group. Three years is too long when they are not qualified for RN status.
2. Saskatchewan–Yes, those RNs are psychiatric nurses.
   Ontario–They are RNs with a psychiatric nursing specialty.
   Alberta–Are called RNs who specialize in psychiatric nursing.
   British Columbia–They are RNs with this specialty.
   Nova Scotia–They are both RNs and psychiatric nurses.
3. Manitoba–Brandon offers a 3½ year combined course with Brandon General. Enrollment has increased each year. It is an excellent course and produces high caliber grads but the wisdom of continuing it is doubtful. The cost in administrative and time and cost to students is excessive. The cost is condoned by hospital management in that it secures supervisory nurses from its grads. The training is inconsistent with the other two provincial schools and needs adjusting.
   Ontario–Four combined schools now offer the combined course but these should be continued in just one or two hospitals.
   Nova Scotia–One combined course. It should be continued until all general schools offer the psychiatric affiliation to all the province's students.
4. Saskatchewan–SRNA has recommended the 2 or 3 month affiliation as soon as mental hospitals or psychiatric wards are made available to our students. It is elective in 7 of 10 schools and required in the degree course.
   Manitoba–MARN does not require an affiliation for registration. The problems are the inadequacy of teaching personnel in most Manitoba mental hospitals and the over-dependency of general hospitals on student service.
   British Columbia–RNABC does not require. It will be required whenever the provincial mental hospital can provide a course–for years we have

urged government to increase residence space and obtain teachers for the mental hospital.

5. Saskatchewan–Psychiatric Aide course does not apply to this province for we now have the new psychiatric nurses.
   Manitoba–The training in this province is complex and is a matter of great concern that the mental hospitals in Manitoba continue to exploit young women by requiring three years training–their diploma is not recognized outside the province. There is a serious need for uniformity between the three hospitals. Each hospital designed its program around what the hospital expects to gain from the student worker. MARN favours a uniform training program for psychiatric aides or practical nurses.
   Ontario–This association recommended the nine months' certified nursing assistant course for Ontario Hospitals. There is a great need to provide assistance to registered nurses.
   Alberta–Our aides here are called graduate attendants or psychiatric nurses (female) and their course is three years.
   British Columbia–The two year program for mental hospital workers graduates licensed psychiatric nurses.
   Nova Scotia–Aides should be trained on-the-job to assist the RN.[76]

It was understandable that Dr. Roberts was overwhelmed by the confusing state of psychiatric nursing and non-professional mental hospital work in Canada.[77] Organized nursing from province to province displayed a wide variation of responses on most of Roberts' questions, with nurses west of Manitoba recognizing the new group of registered or licensed psychiatric nurses in response to their provincial governments' legislation. The varied responses reflected Canadian nursing's lack of control around education for psychiatric nursing. The terminology issue was frustrating. Some of the western nurses' associations approved of the term psychiatric nurse for the new group but at the same time suggested that registered nurses could specialize in psychiatric nursing. And except for the MARN, none of the other western provincial associations challenged the psychiatric nurse designation for the new group. It was notable that the three associations west of Manitoba perceived that the new psychiatric nurses had taken the place of the former attendants. Without the newly legislated group in Central and Eastern

Canada, there was a role for psychiatric aides. Manitoba nurses again stood out in their response to the combined training program–of all the provinces the MARN was the only one which disapproved of the combined program offered at Brandon's two hospitals. The other associations perceived the value of the combined program, at least until affiliations were firmly established.[78]

Coincidentally, Roberts' first meeting with his Advisory Committee on Mental Health and the CNA's biennial were both held in June, 1952. Hall efficiently forwarded all the completed provincial nurses' associations' questionnaires to Roberts in time for his meeting.[79] However, in spite of the fact that this issue was on the CNA's own biennial agenda, its educational policy committee did not receive the information collected for Roberts.[80] Canadian nurses were asked to tackle Edith Pullan's problem of strained relations between registered nurses and psychiatric nurses in British Columbia, and the variable training of non-registered mental hospital staff across the country. For the first time, psychiatric nursing issues received attention at the national level. The following resolutions were passed:

1. Whereas the training and status of nursing care of psychiatric patients is confused...a special committee be appointed to study the problem of the preparation of non-professional psychiatric nursing personnel.
2. Whereas the need for experience in psychiatric nursing has been emphasized in the report of the evaluation of the Metropolitan School of Nursing, Windsor,...every effort be made to establish psychiatric nursing experience in the basic course.[81]

As the CNA's committee on educational policy was appointing nurses to serve on the new committee, it concluded that committee members also ought to examine the educational preparation of registered nurses for psychiatric nursing practise. It was believed that the two groups could not be looked at in isolation. Marjorie Russell had

recently chaired a CNA committee on auxiliary nursing staff and was appointed as chairman of the new committee. The very large committee was divided into two sub-committees–the professional course and the assistant course; and another called the special working committee meshed the sub-committees' work.[82] It was a huge project, and nurses from across the country were appointed to the committees.[83] Just as the committee work was underway Dr. Roberts notified Pearl Stiver, the CNA's new Secretary-Treasurer, that he was hiring a psychiatric nurse consultant on a two-month contract to study the non-professional mental hospital staffing issue and design a standardized Canadian curriculum for the auxiliary worker.[84] Stiver was surprised that the federal government's Mental Health Division was taking on a project which CNA delegates had deemed to be a nursing responsibility–the training of mental hospital auxiliary workers. Roberts, however, was acting upon the desperate resolutions put forward by the provincial directors of mental health at their last meeting.[85]

And so it was that in January, 1953 both the federal government's Division of Mental Health and the CNA each began studies of the mental hospital auxiliary worker, with the intent of creating a standardized curriculum. Stiver was surprised that the federal government was taking on the project. The CNA had assumed that, like the auxiliary general hospital worker, the training of mental hospital auxiliary workers fell under the responsibility of registered nurses.[86] But there was an important difference–registered nurses did not have a strong presence in mental hospital nursing care throughout most provinces, and moreover, held little authority over mental hospital training. Nevertheless, once Roberts and Stiver discovered the similarity in their projects, it was remarkable that neither suggested collaboration. Stiver only hinted: "We would be pleased to have

knowledge of your plans so that we will not duplicate work already being undertaken".[87] This federal project and how it was influenced by the ambitions of certain Western Canadian psychiatrists are examined next.

The Federal Government Survey of Non-Registered Mental Hospital Staff

It had been Alberta's Dr. Randall MacLean who pushed for action on the non-professional mental hospital staff and he and Roberts arranged for Edith Kemp, Superintendent of Nurses at the Ponoka Mental Hospital, to travel to Ottawa to take on the project. Kemp was a registered nurse with a post-graduate psychiatric nursing course from McGill University.[88] Roberts decided that because his division had Elsie Ogilvie's survey results and the data collected by Gertrude Hall and the CNA, Kemp only needed to survey the mental hospitals regarding the non-professional training courses taught, and from the data collected develop a standard curriculum.[89] At the start of their work, neither Roberts nor Kemp used the term psychiatric nurse, but rather non-registered mental hospital personnel.[90] But perhaps as a harbinger of what was still to come regarding this terminology, Dr. A. Gee, Director of Mental Health Services for British Columbia commented:

> I look forward to the day when there will be standardization of training for psychiatric nurses....It has been my worry that the rest of the provinces would not advance to the same level to which we have attained with an Act and a new two year psychiatric nursing education program.[91]

Ironically, it was Gee's own Superintendent of Nurses, Edith Pullan, who had alerted the RNABC and the CNA to concerns about variations in mental hospital workers' training courses and the tense relationships between registered and psychiatric nurses.[92] The following is a sample of the responses received by Roberts and Kemp:

> Dr. Sam Lawson, Medical Superintendent, North Battleford Mental Hospital–Graduates of our 3 year 516 hour training course are called Registered Psychiatric Nurses. Males need grade 10, females grade 11. They are employed as staff. Vacancies occur through the year but they wait for classes and work. There is not any shortage of applicants. Men and women are paid the same monthly salary ($140.00 a month for first year, $165.00 in second year and $177.00 in final year). There are no ward teachers and no textbooks are required. We cannot train in less than 3 years. Our grads have the same responsibilities as RN graduates.[93]
>
> Dr. Stuart Schultz, Medical Superintendent, Brandon Hospital for Mental Diseases–Graduates of our two year 649 hour training course are called psychiatric nurses (females). Grade 10 or 11 required. They do not work on the staff before classes commence. Applicants have been decreasing for this course as most now enter our combined course. We have been making plans to add a six-month practical nursing course to the first course to give students general hospital experience.[94]
>
> Laura Fair, Supervisor of Nurses, Ontario Hospitals–We are planning a ten-month, 260 lecture hour course for psychiatric aides to work under RN direction. Grade 10 is required.[95]

Kemp reported that there were 4,567 mental hospital aides and attendants across Canada and 1,053 mental hospital graduates from Manitoba, Saskatchewan, Alberta and British Columbia. Mental hospitals in Central and Eastern Canada employed considerably more registered nurses and aides than in Western Canada. To illustrate this finding she compared Ontario and British Columbia staffing patterns:

	Ontario	BC
RNs	483	27
non-RN mental hospital graduates	85	387
aides/attendants	2,181	8 [96]

Although Kemp was employed by the Alberta government, she was critical of the training programs in the western provinces' mental hospitals:

> This is a confusing and varied group of ten schools developed to meet hospitals' needs. In many hospitals service to the hospital comes before learning. Students are obliged to carry out nursing procedures on patients before being taught. Graduates are called "psychiatric nurses" whether legal or not. Training varies between the provinces, between schools

> within a province and between genders in some schools. Their courses are not educationally sound.[97]

Kemp pointed out that the number of registered nurses employed by mental hospitals was the highest it had been since the war years, at 900. However, this was only 2.9% of Canada's 30,000 practising RNs. She noted that immediately following World War II, the United States federal government and organized nursing had made a better effort than Canada to educate more RNs to provide psychiatric nursing care.[98] She was impressed with new training courses for nurses' aides in Canadian general hospitals and believed that similar courses needed to be offered in mental hospitals. She stated that "the whole situation in Canadian mental hospitals is in a confused and critical state and it is obvious that there is an urgent need to make changes".[99] Her report to Roberts recommended:

1. A standard course for psychiatric hospital nursing aides be established in all provinces.
2. Standards of education and practise for aides be approved by provincial or national agencies.
3. Provision be made for licensing aides.
4. Course to be 12 months in length with an educational focus, not service, with small monthly allowance provided.
5. An urgent appeal be made to the CNA to take steps to prepare RNs for the psychiatric nursing specialty.[100]

Kemp presented her report to the March, 1953 meeting of the Subcommittee on Training, a committee of the larger Advisory Committee on Mental Health. Besides Roberts, members included Laura Fair, Dr. Gee (BC) and Dr. George Reed (Quebec). Sensing that Kemp's recommendations would be contentious, Roberts advised that he was dispensing with formal minutes so that there could be an open discussion amongst members.[101] No doubt Dr. Gee discussed the fact that Kemp was recommending that the twelve-month psychiatric nursing aide course replace the new two and three-year psychiatric nursing programs found in British Columbia and Saskatchewan.[102] The

Advisory Committee on Mental Health had passed a resolution requesting a standard course and that is what Kemp was contracted to deliver.[103] Further, her calculations showed that these two western provinces would save substantial money by shortening their courses.[104]

Instead of minutes, Roberts drafted a "report of the subcommittee on training to the advisory committee on mental health". Roberts circulated it to subcommittee members for their feedback, and for the first time Roberts used the designation "psychiatric nurse", obviously influenced by Gee's lobby.[105] Roberts advised that these subcommittee recommendations would accompany Kemp's report:

1. The CNA accept the term psychiatric nurse as defined in British Columbia.
2. The duties of the psychiatric nurse should be supervised by the registered nurse.
3. The CNA recommend to its provincial associations that some recognition be given to the training of psychiatric nurses.
4. Psychiatric nurses who meet requirements for registration be given opportunities to further their education.[106]

Without minutes it is not known what Fair said at their meeting but her written feedback did not challenge Roberts' additional recommendations. However, she pointed out that in Ontario, mental hospital aides would be directed by RNs.[107] Quebec's Dr. George Reed informed Roberts that the separate designation "psychiatric nurse" would not be recognized by the nursing profession in Quebec.[108] And like Fair, Kemp too accepted the new psychiatric nurse terminology. She wrote: "If all the provinces obtain legislation for the use of the term "psychiatric nurse" there will have to be a change made in Quebec".[109] In her report, Kemp's comments about the unique training in the western provinces were harsh, so it was evident that she had been influenced by Drs. Gee and Roberts' psychiatric authority and deferred to their position.[110]

While Roberts was refining his report for the Advisory Committee on Mental Health, he and Pearl Stiver had frequent communication about the CNA's own project on psychiatric nursing.[111] In particular, Roberts wished to include the CNA report on the auxiliary worker with his report. Stiver explained:

> The delay in forwarding a statement regarding the deliberations of the psychiatric nursing subcommittee is regretted....The delay is due to the difficulty in obtaining a study of the statement by members of the educational policy committee. Pending the finalizing of the report and then its approval by our executive may I provide you with an outline of the CNA's consideration of psychiatric nursing education. As far back as 1929...Dr. Weir surveyed....Since the publishing of the Proposed Curriculum for Schools of Nursing in Canada in 1936 the CNA through the provincial associations has endeavoured to meet its recommendations. Attempts have been made to require a psychiatric nursing affiliation for registration in some provinces. Many obstacles have been met by nurses – a lack of facilities and instructors to name only two. We hope to have an interim report in your hands prior to your September meeting. Dr. Roberts, may I assure you of the concern of the CNA in meeting the nursing care needs of psychiatric patients....[112]

Almost a year had passed since the CNA subcommittees started the project and its special working committee had spent several days on a retreat but was unable to finalize the interim report.[113] Nevertheless, Stiver was unnecessarily defensive, deferential and apologetic about the delay, considering Roberts did not share Edith Kemp's report with her association as she requested.[114]

Kemp's report, together with Roberts' subcommittee on training report, created angst for some at the meeting of the Advisory Committee on Mental Health. Although Roberts had carefully ensured that the term "psychiatric nurse" was included, Dr. McKerracher was fearful that if Kemp's recommendation for the much shorter psychiatric nursing aide course was adopted by all the directors of mental health, there would be a loss of "nursing service" for psychiatric patients. The aide course

recommended by Kemp was to be educationally oriented, whereas McKerracher's program was based heavily on service.[115] He asked for her report to be held and for the Advisory Committee to wait one more year and monitor the staffing problem. He stated that "psychiatrists should decide what their needs were and what they wanted, and then meet those needs".[116] He asked Roberts to appoint a psychiatrist to study the mental hospital nursing problem, making it a possibility that McKerracher had used the same argument around Ogilvie's lost appointment.[117]

Ontario's Dr. Montgomery expressed satisfaction with Kemp's report because it reflected his province's situation. He explained that the RNs employed by the Ontario Hospitals displayed leadership, more RNs were joining the mental hospitals' staff and the province's psychiatric aide course was almost ready to be taught.[118] Drs. Gee and McKerracher reminded their eastern colleagues that the new psychiatric nursing profession was legislated by their provincial governments. Further, they requested representation by the western psychiatric nursing profession at future national discussions.[119] Gee warned his colleagues that if the psychiatrists did not act to organize a standardized training program for mental hospital staff across the country, another group would take over the training.[120] Gee, of course, was cognizant that the CNA was working on such a project and that the British Columbia and Saskatchewan psychiatric nurses' training would not be recognized if the CNA had responsibility for auxiliary workers' training. Because of the dissent expressed by McKerracher and Gee the Advisory Committee accepted neither Kemp's or Roberts' reports. Instead, the Subcommittee on Training was asked to clarify its position on a training course for non-registered mental hospital personnel. It had then been over a year since their resolution was introduced and

it was no longer clear that these provincial psychiatrists were all headed in the same direction–was it about a training course for auxiliary staff or a new nursing profession?[121]

Auxiliary Staff or a New Nursing Profession?

Roberts received the CNA's interim report a few days prior to his Advisory Committee meeting,[122] but not all members of the educational policy committee agreed that it ought to be shared with Roberts at that time. The subcommittees were still collecting information and some wanted the report completed. Nettie Fidler, by then Director of the School of Nursing at the University of Toronto, pointed out that the acceptance of their report and its recommendations "would depend upon Dr. Roberts' success in influencing the thinking of his provincial counterparts".[123] Her perceptions about Roberts' influence would prove to be accurate.

The interim report acknowledged the serious shortage of RNs at mental hospitals and attributed the situation to the lack of student affiliations, the fault of both general and mental hospitals. It noted that "without student affiliations there is a lack of knowledge and experience, creating fear in the registered nurse about caring for mentally ill patients".[124] It identified some issues and recommendations:

> A belief that nursing in psychiatric hospitals has less prestige than at general hospitals.
> Male attendants often have comparable status and a higher salary than registered nurses, although their educational preparation is much less.
> Some institutions in the western provinces will not hire registered nurses who are interested in psychiatric care unless they have prior psychiatric nursing experience.
> Working relations between RNs and mental nurses at some mental hospitals in the West are not harmonious.
>
> Recommendations
>
> 1. Increase residence space.

2. Increase qualifications of nursing instructors through the use of federal health grant.
3. Standardize a 9-12 month course for male and female auxiliary workers, to be done on a national basis with licensing.
4. A joint committee of CNA, CMHA and the Mental Health Division to work out details.[125]

Drs. Roberts, Gee and McKerracher communicated among themselves following the contentious Advisory Committee meeting, and Roberts sent these two colleagues the CNA's interim report, advising them that he would hold it back from the rest of the Advisory Committee members until the Subcommittee on Training met.[126] However, while Gee was chairman of the Subcommittee on Training, McKerracher was not even a member.[127] Further, Roberts deceived Dr. Donald Cameron, Deputy Minister of National Health and Welfare, advising him that the CNA report was distributed to the full Advisory Committee on Mental Health.[128] These three psychiatrists did not want their colleagues to learn that the CNA recommendation concerning the course for mental health auxiliary workers was almost identical to that which Edith Kemp had advised. By ensuring that their eastern colleagues were kept in the dark, Roberts bought time to influence Cameron. Gee and McKerracher made it clear to Roberts that neither of them liked the CNA report and Roberts echoed their beliefs about who controlled mental hospital training:

> Some mental hospital administrators have precise ideas regarding the requirements for mental hospital nursing and they have developed effective programs to meet this need. It is unfortunate that the thinking and persistence of these doctors has not permeated the whole field.[129]

Roberts reassured McKerracher that: "I will be giving this matter a great deal of careful attention and any move we make will improve the training of mental hospital staff."[130] It

was evident that Roberts had not yet clarified his own position about exactly who that mental hospital staff ought to be–auxiliary workers or psychiatric nurses.

Perhaps sensing some ambivalence, McKerracher was not reassured. The stakes were high, for if both the Kemp and CNA reports' recommendations were accepted by the Advisory Committee on Mental Health, his new three-year psychiatric nurse training program would never be embraced by provincial governments east of Saskatchewan and its value would diminish. Or worse, there was a chance that his psychiatric nursing program might disappear in Saskatchewan. So as he had done in 1948,[131] he manipulated the situation in order to incite others, this time his province's psychiatric nurses. He used sections of Kemp's report, along with pieces from the CNA's interim report, and developed a new paper *Report on RN Study Made to Sub-Committee on Training*, and presented it to the council of the SPNA.[132] McKerracher interpreted both reports' implications from the perspective of his province's psychiatric nurses. For example he wrote:

> The implication is strongly evident that the recommendation is the replacement of the varied mental hospital courses by a national standardized one-year course at a sub-professional level. Would the inferior status and lower salary of these graduates have an effect? Could the mental hospital handle a one-year course in which no service from students was expected? It is obvious that standardizing at a lower level than the present Saskatchewan training course would involve a reduction of salaries and a curtailment of promotions. Would Saskatchewan mental hospitals have more to gain by going with standardization or by focusing on improving the professional status of the present three-year psychiatric nursing course?[133]

Not only did McKerracher's paper agitate Saskatchewan's psychiatric nurses, but their British Columbia colleagues were also affected when a copy of the paper made its way to that province.[134] Dr. Gee was irate about the two leaked documents and notified Roberts:

> It is detrimental to the cause of the psychiatric nurse and is creating dissatisfaction in British Columbia. I cannot understand how or why it was put into the hands of our psychiatric nurses.[135]

Initially Roberts blamed Pearl Stiver and the CNA for the leak and "creating more tension in the west".[136] He was therefore surprised when Gee discovered that the culprit was one of their own.[137] And although Gee asked Roberts to remind McKerracher that their committee work was confidential, Roberts neither confronted McKerracher about the breach nor apologized to Stiver.[138] McKerracher's mission was accomplished: the provoked psychiatric nurses woke up to the threat of their young profession's extinction and joined in the battle with McKerracher and Gee to save their training program. They asserted, through their Secretary, William Butcher:

> Since 1947 there has existed in Saskatchewan, British Columbia and Alberta three professional associations of Psychiatric Nurses....In 1950 these three groups formed the Canadian Council of Psychiatric Nurses and in cooperation with our progressive Directors of Mental Health, we have raised the standards of care in our provinces. We feel that in this highly specialized field of nursing, only psychiatric nurses can provide services of value to patients. Since we constitute 90% of nursing staff in our mental hospitals, Psychiatric Nurses feel that they are entitled to have three representatives from our three associations to sit in on the planning for future training of Psychiatric Nurses in Canada.[139]

It is not known if William Butcher received assistance from Dr. Gee with the letter's composition, for the request was similar to that demanded by Gee and McKerracher at the Advisory Committee meeting. Notably, Butcher reiterated the identical message that some psychiatrists in the west had been articulating since Dr. MacNeill's day–only specially trained psychiatric nurses could provide mental hospital nursing care.[140]

In accordance with his promise to Gee and McKerracher, Roberts contemplated how to proceed with a national course for the non-registered mental hospital worker. While he could not change Kemp's report, he clarified the report of his own

Subcommittee on Training, revising it in an attempt to make it more palatable for Drs. Gee and McKerracher.[141] The definition of psychiatric nurse was made explicit and psychiatric nurses no longer required supervision by registered nurses, as follows:

1. The CNA accept the British Columbia definition of the psychiatric nurse as any person who has attended an approved school for the training of psychiatric nurses...and passed examinations in psychiatric nursing....entitled to licensing as a psychiatric nurse.
2. The duties shall be carried out under the direction of a physician and under the supervision of a qualified person.[142]

Roberts reconvened the Subcommittee on Training but first made some changes to its membership. Dr. Robert Montgomery replaced Laura Fair; Dr. Humphrey Osmond, Medical Superintendent at the Weyburn Mental Hospital was nominated by McKerracher, Dr. George Reed continued for Quebec; and Dr. Gee served as chairman.[143] While the members accepted Roberts' revised recommendations, some of these psychiatrists made disparaging comments about registered nurses. Roberts wrote the minutes and because he did not use the doctors' names it was not clear as to who said what. The CNA's interim report received attention and Gee stated: "This is the first time in the history of Canadian nursing that registered nurses were ready to confer on mutual problems".[144] The minutes summarized their discussion:

> The necessity to understand what motivated resistance and antagonism of the RNs to psychiatric nursing was discussed. One member stated that RNs who worked at mental hospitals were considered as outcasts by their colleagues....this resistance could be applied to the medical profession. The economic factor was a historic reason used by RNs against expanding the nursing ranks and as a deterrent to progressive action. General trained nurses needed to re-orient themselves because they babied psychiatric patients. Another member disagreed, stating he found RN training satisfactory. The affiliation course for student nurses was a concession to the needs of the mental health field generally but did not help solve the problem of staffing mental hospitals...and few ever returned to make psychiatric nursing a career. One member felt that soon all the top positions in mental hospitals would be held by psychiatric nurses and RNs

> would function only on sick wards and operating rooms. Members agreed that the report from the CNA held good promise for negotiation, despite the unfortunate implications about "auxiliary nursing personnel" to have a course of only 9-12 months duration. If this recommendation was implemented it would give the new psychiatric nurses a considerably inferior status.[145]

The members discussed finding a training plan for mental hospital personnel that was acceptable to both the CNA and the western provinces' psychiatric nurses. They recommended that representatives of the CNA and the Canadian Council of Psychiatric Nurses (CCPN) should meet with their committee "to further congenial relationships between the two groups".[146] His minutes revealed that Roberts was doing much more than attempting to placate Gee and McKerracher. He was no longer ambivalent about which direction a national standardized training course should take and most likely he, Gee, and Saskatchewan's Dr. Osmond, hijacked this meeting's agenda.[147] There was no evidence that Ontario's Dr. Montgomery openly disagreed with the direction taken. However, when he later advised Ontario medical superintendents that the federal government wanted to move the western training program eastward, he heard only negative comments.[148] One wrote:

> The invasion of non-registered "nurses" into a medical program is a backward step in the care of mentally ill people. We are not interested in glorified ward aides. Psychiatry is a piece in medicine and psychiatric nursing is a piece in nursing. We will not separate the mind and body.[149]

The provincial directors of mental health had originally requested a standardized course for non-registered mental hospital auxiliary staff. Kemp's report recommended such a course be twelve months in length and the CNA suggested a nine to twelve month course.[150] But these minutes clearly revealed that at this meeting, the focus changed from the original need for an auxiliary worker course to the much longer courses for

psychiatric nurses being taught in British Columbia and Saskatchewan. Kemp's report was ignored. Moreover, just as the Saskatchewan government had legislated a newly-defined profession of psychiatric nurses in 1948,[151] five years later and without nursing input, these psychiatrists recommended that the CNA and its nurses needed to accept a similar definition of psychiatric nursing.

In an attempt to justify to Deputy Minister Cameron the new direction he was taking with this issue,[152] Roberts requested that Dorothy Percy, the Department of Health and Welfare's newly appointed Chief Nursing Consultant, review his revised report and minutes from the Subcommittee on Training. The CNA had lobbied for over five years for the creation of Percy's position, and although she had been consulting part-time while carrying out her work with the Civil Service Health Division, this was her initial step into the work of the Mental Health Division.[153] She provided Roberts with an objective and unbiased nursing perspective:

> I am a little perplexed by the sentence about the 9-12 month course, "The subcommittee felt that this suggestion, if implemented, would give the psychiatric nurse a considerably inferior status". Is it the "psychiatric nurse" who is now being considered here? I thought it was auxiliary personnel....While I can understand the desire of western Canada's "psychiatric nurses" to organize their own group and I can see the necessity of recognizing a fait accompli (their Canadian Council of Psychiatric Nurses) I cannot but deplore this splitting off from the main body of nursing. Consultation between the CNA and this new group would be of definite value, with the long-range plan of reaching some agreement as to their eventual inclusion into the main stream of nursing. One of the main difficulties is that many of these "psychiatric nurses" would not be eligible for registration as nurses. The key in dealing with this group should be sympathetic understanding...acknowledgement that they are doing a job in the field and will have a place in the mental hospital picture....If the auxiliary nursing personnel are to be prepared solely for mental hospital work, one year might be sufficient, but if a double mental with general preparation is visualized then 18 months would be a minimum.[154]

It was remarkable that this was the first time in the eighteen months since the doctors had been dealing with this issue, that someone pointed out the discrepancy between the original intent of the Advisory Committee on Mental Health's resolution and Roberts' Subcommittee on Training's changed focus to the Western Canadian psychiatric nurses. Percy respected the fact that the Saskatchewan and British Columbia psychiatric nurses fell under provincial Acts, forcing their recognition by the federal government. However, she did not understand that the Canadian Council of Psychiatric Nurses was an informal association lacking legal authority and possessing a small membership from just three provinces.[155] Enclosing the term "psychiatric nurses" in quotes indicated a reluctant acceptance of this group by Percy. However, she did not endorse national adoption of their training program.

Roberts also wanted a current picture of the status of psychiatric nursing education for general nurses in Quebec and Ontario. Percy obtained some information:

> Rae Chittick, Director of the School for Graduate Nurses, McGill University is not convinced that the answer is post-graduate courses in psychiatric nursing but rather instruction for all students. She believes that there needs to be advertising done around the available federal bursaries for the courses at McGill and the University of Toronto...someone should be out there recruiting for these courses. Miss Lamont, Director of Nursing at the Royal Victoria Hospital, Montreal, believes that psychiatric wards in general hospitals are the answer to the difficulties in sending students on mental hospital affiliations. Laura Fair states that the Ontario Hospitals prefer the registered nurse, nursing aide combination over the new "psychiatric nurse". There are 4,000 aides working in their institutions and their new course is almost ready. All but three schools in Ontario send their students (some or all) on affiliations and this year 1818 general students will receive the twelve-week affiliation. All the Ontario Hospitals could take more students if residence accommodation was increased. She said that numerous students are interested in pursuing a career in psychiatric nursing during the affiliation but that something else gets their attention upon return to their home school.[156]

Although both Fair and Dr. Montgomery had been members of the Mental Health Division's Subcommittee on Training, neither had expressed any concerns to Roberts about the possibility of training the new western psychiatric nurses in Ontario.[157] Fair was the only nurse and female member amongst male psychiatrists and her silence on the issue could have been related to her gender and the doctors' authority. In contrast, she had no qualms advising Canada's Chief Nursing Consultant that Ontario was not interested in the new western psychiatric nurse training program. It was obvious that Ontario was not waiting for Roberts and his federal Advisory Committee on Mental Health to agree on a standardized mental hospital training course.

Roberts and Gee spent a lot of time preparing for what they called the joint meeting between the CNA and the CCPN. Some of their time was spent on problem-solving with the CCPN. The western group was unable to agree on two council representatives and instead requested one representative from each of the three provinces–Saskatchewan, Alberta and British Columbia. When he learned that all three provinces were sending male representatives, Gee explained that "men have taken the lead in organizing psychiatric nurses in our provinces and men occupy the executive positions".[158] Roberts was not pleased with the male-dominated western representation and suggested that Gee ought "to find at least one woman...because this picture is complicated by all men".[159] The CNA's interim report to Roberts pointed out perceived salary and status inequities between female registered nurses and less educated male attendants, and Roberts feared these men could reinforce that perception.[160]

The CCPN was unable to find a female psychiatric nurse to attend the April 1954 joint meeting. Mr. William Butcher, Mr. E. Campbell and Mr. Richard Strong attended

along with the CNA's Pearl Stiver, Helen McArthur, President, and Frances McQuarrie, nursing education secretary. Drs. Gee and Reed represented the Subcommittee on Training, and Dr. Roberts and Dorothy Percy attended for the federal government's Health and Welfare Department.[161] Gee explained that the Subcommittee on Training had a special interest in the psychiatric nurses of Saskatchewan, Alberta and British Columbia and that in those provinces, ward aides and attendants in psychiatric hospitals were few and far between. In comparison, east of Saskatchewan the aide was seen as an auxiliary worker and those provinces in turn had a large number of ward aides.[162] Gee advised the meeting:

> Further progress at this joint meeting would seem to hinge on an acceptance of the term psychiatric nurse, as understood in British Columbia and Saskatchewan, as an integral component of the mental hospital team. If we had agreement as to the need for this psychiatric nurse, the way would then be clear to consider whether there could be a minimum curriculum and national examinations for psychiatric nurses in Canada. It is further felt that arrangements for recognition of portions of psychiatric nurse training toward RN qualifications be made. We would like to solicit the cooperation of the CNA in furthering these aims.[163]

Helen McArthur reviewed the work underway on the CNA's report *Preparation of Nursing Personnel for the Care of the Mentally Ill*. It was to be presented at the June, 1954 biennial meeting and she advised the joint meeting that any action taken was dependent upon the outcomes of this report to CNA delegates.[164] Although she later reported that she perceived that Gee's request was a "plea from the psychiatric nurses and Roberts",[165] McArthur made it clear that she was not prepared to commit the CNA to anything more than a readiness to study mutual problems and cooperate with all concerned groups.[166]

In spite of Percy pointing out to Roberts what she saw as a discrepancy between the Advisory Committee of Mental Health's original request for a standardized course for mental hospital workers and the subcommittee's new focus on the longer psychiatric nursing course, it was clear from these minutes that Roberts had ignored Percy's concern.[167] This was about psychiatric nursing in the three western provinces.[168] Percy did not revisit her concerns at their joint meeting and a decade later she recalled that the three male psychiatric nurses had been "single-minded and persistent in their dealings with the Mental Health Division".[169]

Following the joint meeting Roberts asked Deputy Minister Cameron to exert the federal government's authority and to reiterate to the CNA the Subcommittee on Training's request for cooperation. Cameron wrote:

> It is desirable to arrive at a minimum curriculum and a national examination for Psychiatric Nurses in Canada. It is also believed that recognition of psychiatric nurse training toward RN qualifications is desirable....I hope that your association will give favourable consideration....[170]

Roberts' maneuvering had paid off. Suddenly the picture was immensely brighter for Gee and McKerracher. Their lobby of Roberts was a success and Kemp's recommendations had disappeared from the agenda of the Subcommittee on Training. With the federal government endorsement of a Canadian curriculum and examination for psychiatric nurses, their goal was within reach. The power wielded by these three conspiring psychiatrists was staggering. As described next, the chronic struggle between medical psychiatry and nursing for control of education for psychiatric nursing escalated into a battle.

Specialty or Profession? The Battle in Banff

Cameron's request came just as the final touches to the CNA's report, *The Preparation of Nursing Personnel for the Care of the Mentally Ill,* were being made. Ever since the 1952 biennial meeting's resolutions concerning the need to study both professional and non-professional preparation for mental hospital care were passed, an immense amount of CNA time, effort and money had gone into this report's preparation.[171] Roberts had received the committee's interim report and the remainder was completed for the 1954 biennial meeting:

> The shortage of nurses is worldwide but there is little doubt that in Canada the nursing shortage is most acute in psychiatric hospitals. With an increased demand for more nursing care, hospitals and provinces have been forced to recruit and prepare whatever staff they could. Many workers have little preparation. Further, new psychiatric wards are now under construction....The problem of how to provide more adequate nursing care for the mentally ill is complex. It will continue to be with us for a long time. The obvious and ineluctable conclusion is that how to best provide adequate nursing care for the mentally ill cannot be solved by the CNA alone.
>
> Certain factors have a bearing on the difficulty securing RNs for psychiatric hospitals. The majority of schools do not provide psychiatric nursing experience. Reasons for this lag include a shortage of mental hospital accommodation for students, service requirements by general hospitals and inadequate teacher preparation. Such conditions deter provincial nurses' associations from making psychiatric nursing a legal requirement for registration. Until this is done the situation will continue unchanged.
>
> Recommendations
>
> 1. The basic curriculum be revised to provide for increased emphasis on psychiatric nursing.
> 2. Psychiatric nursing should permeate the entire curriculum.
> 3. All nursing instructors need some preparation in psychiatric nursing.
> 4. CNA take steps to help membership become better informed about psychiatric hospitals and their nursing needs.
> 5. CNA recommend to provincial associations that they cooperate with mental health departments in providing increased nursing care to mental hospital patients.

6. All courses preparing auxiliary personnel should provide both general and psychiatric nursing instruction. Such courses to be a standardized 9-12 month curriculum with licensing.[172]

Over the same two years both the CNA and the Mental Health Division of the federal government had struggled in isolation with the identical problem–a lack of trained mental hospital staff. There had been minimal communication between the psychiatrists on the federal Subcommittee on Training and the registered nurses on the CNA subcommittees which developed this report.[173] It was therefore not surprising that their reports and recommendations varied.

The CNA report was released to delegates attending the 1954 biennial meeting in Banff, Alberta and accompanied by a symposium, *Pathways to the Future in Psychiatric Nursing in Canada*.[174] Psychiatric nursing issues dominated the Banff meeting. Dr. Roberts had been invited to speak on mental health problems.[175] However, he told his audience that he had switched his assigned topic to "nursing problems in mental health in Canada":

> ...It is now believed that psychiatric nursing is inherently different from general nursing. The training of an RN and the general hospital orientation is to care for physical illness and it is felt that a three month psychiatric affiliation will fall short in providing mental hospital nurses....It is true that new psychiatric units in general hospitals are broadening the physical focus but they will not replace mental hospitals. The mental and general hospital are different. It is my belief that the care of psychiatric patients is mostly psychosocial with a secondary interest in physical care. It is therefore believed by many that this nursing staff needs a minimum of general training but lots of psychiatry. It has been suggested that the use of RNs supplemented by nursing aides will meet the mental hospitals' needs. This is impossible. Thus it seems to many of us that a clear case exists for the training of the new profession of psychiatric nursing. This new professional nurse would have equal status to the RN....There is no need for anxiety regarding these points but there is a need for serious thought about my suggestion. A new approach to mental hospital nurse training is required and it is already being done in Western Canada. I hope the Canadian nursing profession will support this new approach.[176]

Roberts came to the Banff biennial convention with his own agenda, and that was to deliver the recommendations of the Subcommittee on Training and a message from the federal government to Canadian nurses. His judgment was poor, for the Advisory Committee on Mental Health had not reviewed Roberts' recommendations; yet it was that committee's resolution which initiated the project. Even Dr. Gee inquired about the relationship between these two Mental Health Division committees.[177] McKerracher clearly had influenced Roberts' thinking regarding a decreased emphasis on physical nursing care for psychiatric patients. Such thinking among Canadian psychiatrists was uncommon in the mid-1950's.[178] Roberts' logic for wanting to institute the new occupation across Canada was based on his belief that mental and general hospitals were different, that mental hospitals would not be replaced, and that these two different hospital environments therefore needed entirely different nurses. However, while there were only about twenty-five general hospital psychiatric units in 1954, that was twenty more than immediately after the war and they were looked upon favourably.[179] Roberts completely negated both Edith Kemp's work and the CNA's final report without explaining why a mix of registered nurses and trained psychiatric aides would not work. He suggested that a new profession of psychiatric nurses ought to replace registered nurses in mental hospitals throughout Canada, but paternalistically advised these nurses not to worry about it.

Elizabeth Bregg, Director of Nursing at the Toronto Psychiatric Hospital and a member of one of the CNA's subcommittees which worked on the new report, followed Roberts on the panel. Bregg was a recent graduate of Teachers College at Columbia

University in New York where she studied under Dr. Hildegard Peplau.[180] She offered her insights and challenged delegates to act:

> Psychiatric nursing has emerged as a specialty of nursing requiring professional preparation and defined skills. The most pressing problem is a lack of interested and prepared nurses to work with the mentally ill. Many reasons for this have been given but there is no one answer. Nursing research is required. Shall we attend to this before some other group does it for us? We nurses have a long history of compliance and backwardness of a self-deprecatory nature to overcome. We are fond of reiterating that we are professionals but the salary commensurate to the purchasing of books, attendance at conventions or the driving of a car is not forthcoming....When we supply hospital accommodation we do it economically in a boarding school environment. The director of nursing in the mental hospital is rarely allowed independent thoughts or actions. Male wards cannot be used for teaching student affiliates because there is no nursing care. The chief attendant is as highly paid as the director of nurses....Such oversights are not unintentional....The complication of the newly created "psychiatric nurse" split from the nursing profession is obvious. It is a stop-gap, but in terms of what this change has done to the future development of psychiatric nursing as a specialized branch of Canadian nursing is nothing short of disastrous. Psychiatric nursing is a science and its specialized skills are therapeutic, not custodial. We need nurses in every province to spearhead an attack...we must turn to our universities and to do so we need more financial support from governments to prepare nurses for psychiatric nursing.[181]

Bregg reiterated some of the points raised in the CNA's new report and articulated the North American generalist nursing perspective which regarded psychiatric nursing as a specialty. Her suggestion to seek out universities for educating nurses for psychiatric nursing was identical to that which was occurring in the United States at that time.[182] She suggested that the new western programs taught custodial rather than authentic nursing care. And just as Dorothy Percy had expressed six months earlier,[183] Bregg was deeply concerned about the split of the new group away from the nursing profession. Her prediction of potential harm to the development of the psychiatric nursing specialty was ominous.

Percy, however, was no longer as concerned about the splitting away of the new group of psychiatric nurses. During her first six months in the new position of Chief Nursing Consultant she was influenced by Dr. Roberts' position and the federal government's support of the new group. Following Roberts' speech she left this note at his hotel desk:

> Dear Charlie,
> Your presentation was masterly. I heard many favourable comments in the lounge...and I just about burst me buttons with pride! Atta boy. My guess is that the cooperation wanted with the CNA is off to a good start.[184]

It was obvious that Roberts and his colleagues had much vested in his participation at the CNA biennial convention. George Carty, Paul Martin's executive assistant, wrote: "You are to be commended for giving the girls something to think about, rather than indulging in the usual trite platitudes that one hears at such conferences."[185] Dr. Gee sent a message stating he hoped that Roberts' speech would gain the CNA's cooperation in developing new psychiatric nursing education programs.[186] Roberts and his colleagues were particularly pleased that the CNA delegates passed a resolution which affirmed a desire to cooperate with the Mental Health Division in studying how to provide better nursing care to psychiatric patients.[187]

Hand in hand with Roberts' speech was a press release from the Canadian Institute of Public Opinion/Gallup Poll of Canada titled *Nursing Mental Cases is Too Hard on Women*. It was not a coincidence that it was released to newspapers across Canada on the day before Roberts spoke at the Banff convention. The press release noted:

> ...only three percent of registered nurses work in mental hospitals. The poll found a striking contrast in views among Canadians in the western provinces and those in other parts of Canada. This is because in Saskatchewan the status of the mental hospital nurse has been changed. They are given special training and commensurate pay. The first question

> asked "Do you think a girl should be encouraged to train in a mental hospital?" The national average for those Canadians who responded affirmatively was 34%, Eastern Canadians 28%, Ontario 33% and Western Canadians 43%. The main reason for saying "yes" was the great need for mental nurses. Those who said "no" explained that it was a terrible strain and hard on the nerves....[188]

It is not known whether CNA delegates at the Banff convention were influenced by the information from this poll. However, the fact that it was used by the powerful federal government to reinforce Roberts' message to Canadian nurses revealed just how critical this issue had become to the government's Mental Health Division.

The specialty of psychiatric nursing was under attack and in danger of being replaced across the country by a new nursing occupation; but except for Elizabeth Bregg's speech, the national nursing community did not outwardly protest.[189] Revealing some political naiveté, Stiver thanked Roberts on behalf of the CNA: "We know, Dr. Roberts, that quite apart from the symposium, it meant so much to Canadian nurses to have you with us and to know of your interest."[190] The next section examines how a handful of nurse leaders determined that the solutions arrived at by medical psychiatry for the separate education of western psychiatric nurses were not appropriate for the whole country, halting an expanding medical monopoly.

A Turning Point in the Battle for Control of Education for Psychiatric Nursing

The passage of the resolution to study how to improve psychiatric nursing care gave the CNA Executive Committee a mandate for action, and it began by appointing a new Committee on Psychiatric Nursing to be chaired by Elizabeth Bregg. In particular, the CNA Executive Committee wanted its new committee to explore what, if anything, could be done about Dr. Cameron's request for a national psychiatric nursing curriculum

and upgrading of the western psychiatric nurses for RN registration.[191] Curricula were gathered by Percy and the CNA from general and mental hospital training schools in order to ascertain whether there was a common piece which could be recognized by both general nursing and psychiatric nursing in Western Canada.[192] The committee reported:

> Upon review of psychiatric nursing curricula for Saskatchewan, Alberta and British Columbia...training does not appear to be adequate to even qualify them for their own hospitals. Their courses need to be strengthened.[193]

The concern was that their courses were a specialized apprenticeship and it recommended that a supplemental program be established for Western Canadian psychiatric nurses who wished to achieve their RN. The report reaffirmed the recommendations contained in the just completed report *The Preparation of Nursing Personnel for The Care of the Mentally Ill* and pointed to the need for its implementation.[194]

Bregg's committee report provoked intense discussion at the CNA's Nursing Education Committee meeting. Bregg was not in attendance but Edith Pullan and Evelyn Mallory explained the need for better quality education for psychiatric nursing, and easily convinced fellow members of the need to develop a combined psychiatric and general nursing program based on the Ontario model, which could be taught in the three westernmost provinces. It became the priority recommendation in the amended Bregg committee report.[195] And while it had only been six months since their biennial convention and adoption of the new report, members of this CNA committee were clearly frustrated with the lack of progress and their lack of control over education for psychiatric nursing. Perhaps they had been inspired by Bregg's appeal for action; for in a concerted effort to break the endless cycle of "no residence space meant no psychiatric affiliation meant no provincial nursing licensure requirement for the psychiatric nursing

experience", they passed a resolution asking the CNA Executive Committee to forward the June, 1954 report to Dr. Cameron with a request that the provincial departments of health take immediate action concerning the residence issue. Roberts had a copy of the report but these educators, perhaps made anxious by his speech to them, wanted to ensure that his deputy minister also had a copy.[196] They were worried that the CNA recommendations were not getting through to the provincial level, and they were right. During preparation of the June report, Nettie Fidler astutely predicted that whether the report had an impact depended upon Roberts' influence with the provincial mental health directors.[197] As members of the Mental Health Advisory Committee, they had seen neither the CNA interim nor final report.[198] A second resolution from the Nursing Education Committee requested that the CNA recommend to its provincial associations that the psychiatric nursing experience be made a mandatory requirement for registration. While the CNA Executive Committee reminded the committee that nurse registration was a provincial matter, both resolutions symbolized an attempt by these leaders to gain control over education for psychiatric nursing.[199]

The optimism which Roberts and Gee felt following the delivery of Roberts' paper in Banff quickly dissipated with the arrival of news concerning the Bregg committee report. Roberts shared his angst with Gee:

> I must admit to some confusion. It now seems to me that some concrete action will have to be taken if anything is to be done to bring about the recognition of western psychiatric nurses...if their courses are to have a standard curriculum and qualifications which will enable them to move freely. It is highly desirable to establish a national board to approve Canadian psychiatric nurse training schools and conduct examinations...similar to the Royal College of Physicians and Surgeons of Canada and the Dental Council. Only through the establishment of such a body can we accomplish our desired aims of having psychiatric nurse training across the country.[200]

Roberts was surprised that his government's authority and the Subcommittee on Training's agenda were not having much impact on the CNA. No doubt adding to his confusion was the fact that one of the bearers of news about the Bregg report was Dorothy Percy. Along with the CNA's Frances McQuarrie, Percy had compared general and Western Canadian psychiatric nursing curricula for Roberts and Bregg's committee, and they assessed the latter curricula as weak. It was the first time since her introduction to the mental hospital staffing issue that Percy had objective information about the western training programs, and as Canada's Chief Nursing Consultant, she was unable to endorse that training.[201]

In an attempt to clarify the situation Roberts asked Dr. Gee to meet with Evelyn Mallory, chairman of the CNA's Nursing Education Committee and Director of the School of Nursing at the University of British Columbia (UBC).[202] Mallory told Dr. Gee that she was "skeptical that the 'psychiatric nurses' of the west could ever be considered a national nursing body representing all of Canada", but that a new combined program could eliminate the curricular weaknesses and allow the western psychiatric nurses to obtain RN qualifications. She saw no possibility of credit being given for psychiatric nurse training as it was then taught.[203]

Mallory had rejected both proposals in which Dr. Cameron had requested CNA cooperation. Gee and Roberts were cautious and even suspicious of Mallory, Bregg, Pullan and perhaps Percy. Roberts wrote: "The confusion is increasing rather than clearing...is it wise for us to be so anxious?...We must be careful."[204] Finally he rationalized it as "another delaying tactic" by the CNA.[205] Roberts likely sensed that he had lost some control over the direction in which the psychiatric nursing education issue

was headed. He was struggling to maintain his psychiatric authority while Mallory, representing the CNA, was making a concerted move to stop the western psychiatrists' attempt to extend their monopoly of psychiatric nursing education eastward. Mallory destroyed Drs. Roberts', McKerracher's and Gee's goal for national acceptance of the western style psychiatric nurse training program but simultaneously offered them help with a new combined curriculum that would assist western psychiatric nurses to become RNs. She took what the federal government had requested from the CNA and turned it around to mesh better with the beliefs of the CNA about generalist preparation. Nurses were to be prepared at the basic level as generalists and psychiatric nursing was one specialty of general nursing, not a separate nursing profession.[206] A combined education program was not purely a generalist preparation but it would serve to pull the western mental hospital graduates into the larger nursing discipline, as opposed to splitting away, as Percy had so detested.[207] Roberts saw it as a delaying ploy but in essence this represented a turning point for all players in the battle for control of education for Canadian psychiatric nursing. The psychiatrist-driven separate and distinct Western Canadian psychiatric nursing education movement was halted at the Manitoba/Ontario border, but western psychiatric nurses were being offered a way to become registered nurses. In the next section, the details of the effort to create a combined program in Western Canada are described, including the project's eventual demise.

The Proposed Combined Program for Western Canadian Mental Hospital Schools: Parting at the Crossroads

The CNA Executive Committee approved the amended Bregg report and Mallory's Nursing Education Committee was requested to develop their recommendation for a combined program which would enable graduates to meet registration requirements and be acceptable to the three western registered nurses' associations.[208] To that end Mallory and representatives from the SRNA, AARN and RNABC quickly developed an outline for a combined general and psychiatric nursing curriculum.[209] The MARN was not invited to participate because there was no association or legal recognition of psychiatric nurses in Manitoba, and further the MARN leadership was not in agreement with the combined program offered by the Brandon Hospital for Mental Diseases and the Brandon General Hospital.[210]

Their report, *Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill,* noted that operating both a separate diploma in mental nursing and a combined program within a mental hospital school was costly.[211] It therefore suggested that a 3 ½ or 4 year combined program should replace the separate diploma in mental nursing programs but that a separate psychiatric nursing program could be superimposed on the combined program if a mental hospital so wished.[212] Further, psychiatric nurses already practising should be able to become eligible for registration by taking the general component of the combined program. This was the "selling feature" of the combined program, for it responded to Cameron's request to the CNA for assistance to psychiatric nurses who wished to become registered nurses.[213] The combined program was designed as a temporary intervention until "every nurse in

Canada's mental hospitals will be registered nurses with preparation in psychiatric nursing".[214] This was not a novel idea. Seven years earlier Elsie Ogilvie had recommended to the federal government that the then eleven mental hospital schools with combined programs ought to be kept operational through the 1950's or until all general students received psychiatric affiliations.[215]

Mallory presented the new report to the joint committee of the federal government's Subcommittee on Training. Except for the absence of representation from the Saskatchewan Psychiatric Nurses' Association and the addition of Edith Pullan, the members were the same individuals who had participated on the joint committee at its first meeting one year earlier.[216] The committee members agreed that the idea of a combined program was a desirable one, and that under the sponsorship of the Mental Health Division a curriculum ought to be developed and offered first as a pilot program in British Columbia. To that end Evelyn Mallory was appointed as chairman, along with Dr. Gee, Richard Strong from the British Columbia Psychiatric Nurses' Association and Edith Pullan. Drs. Gee and Roberts were less suspicious and more optimistic than they had been when the Bregg report was first discussed with Mallory, and were hopeful that this new curriculum committee would have a report ready for the Subcommittee on Training by early 1956.[217] In spite of the fact that the supplementary report's recommendations for Western Canada's mental hospital training schools were developed by registered nurses, the three psychiatric nurses in attendance at the joint meeting were not offended. The minutes noted "a fine spirit characterized the meeting" and one later commented on his delight at the move to improve standards of psychiatric nursing care within the context of RN registration for psychiatric nurses.[218] This conciliatory tone was

in marked contrast to their initial communication with Roberts, when McKerracher had incited their anger toward registered nurses.[219]

Not everyone was as pleased about the decision to initiate a new curriculum in Western Canada as were Gee and Roberts. Ontario's Dr. Montgomery told Roberts that while he liked the idea of a combined course for the west, he suggested that it ought not to be any longer than the three-year combined program which the three remaining mental hospital schools in his province then offered. He quietly reminded Roberts of the pressing need for a shorter training course for mental hospital staff.[220] In Saskatchewan, McKerracher and the province's psychiatric nurses had absolutely no interest in or desire for the combined course, and the move to collaborate with the CNA was perceived as detrimental to the development of a national psychiatric nursing profession. The Council of the Saskatchewan Psychiatric Nurses' Association rejected the joint committee's decision. Vowles explained their rationale:

> The objective of the SPNA is for a separate and distinct psychiatric nurses' association across the nation. That was the reason we joined with British Columbia and Alberta in the first place. We do not want any affiliation with RNs. General hospital training is not the answer for our psychiatric nurses. There is not much difference in this plan than the one now operating at Brandon and Ponoka. It would have been easier for us earlier on to have affiliated with the SRNA.[221]

Just one year earlier, McKerracher, Roberts and Gee had pushed hard for national adoption of the Western Canadian psychiatric nurse training program.[222] However, the assessment by Percy and the CNA that the curricula of the psychiatric nurse training programs in Saskatchewan, Alberta and British Columbia were weak and therefore recognition at the national level unlikely, effectively derailed the plan. Their only hope for professional recognition was to train under a new curriculum. However, for

Saskatchewan's psychiatric nurses, the potential opportunity to train to become registered nurses was the antithesis to their strongly held belief in a separate and distinct psychiatric nursing profession, and they retreated from the national picture in 1955.[223]

Meanwhile the provincial directors of mental health who sat on the federal government's Advisory Committee on Mental Health had, by that point, been waiting four years for its Subcommittee on Training to develop a minimum curriculum for non-registered mental hospital workers.[224] During that time the Subcommittee on Training dramatically changed its focus from a training program for mental hospital aides to adoption of the western style psychiatric nurse training program for all provinces. The CNA's report *Preparation of Nursing Personnel for the Care of the Mentally Ill* had been held back from the Advisory Committee so that the members would not be influenced by its recommendation for a one year nurse aide training course.[225] And finally in 1956, Dr. Gee, chairman of the Subcommittee on Training, announced to the Advisory Committee that Evelyn Mallory and a special new federally-sponsored curriculum committee were developing a combined four-year nursing program for Western Canada's mental hospital training schools.[226] Just one year earlier Gee and Roberts had advocated adoption of the western style psychiatric nurse training programs for the whole country, but neither brought it forward for discussion at the 1956 meeting. The new combined program had simply knocked it off their agenda.[227] It was revealing that throughout these four years only one member of the Advisory Committee on Mental Health ever challenged Roberts about the changed focus or the lack of progress of the Subcommittee on Training toward a standardized training course for mental hospital staff. Perhaps this indicated a trust in the federal government's authority. Finally Professor Bott spoke up:

> When the Advisory Committee was established in 1948 it was concerned to a great extent with the shortage of trained mental hospital personnel in Canada. How much advance has been made in the past six years by the subcommittees? What is the situation in 1955?...[It is]time to take stock of the national situation and supply a report on the progress of the Advisory Committee.[228]

Roberts advised only that he knew how many nurses, psychiatrists and psychologists had been trained under the mental health grant but it was difficult to deal with training needs at the local level.[229]

From mid-1955, Roberts and the Subcommittee on Training had no further direct input into the psychiatric nurse training issue, save for Dr. Gee's reports from the British Columbia curriculum committee.[230] Roberts' position expanded beyond the Mental Health Division as he became involved with planning for the initiation of the federal government's hospital insurance program.[231] While he was a staunch advocate of a public health care system for Canada, he believed that as a federal civil servant his influence on provincial mental health matters would diminish once the new program took effect. Thus, in 1957 Roberts left Ottawa and became the Medical Superintendent at the Verdun Protestant Hospital near Montreal.[232] Roberts later concluded that his division's involvement with the CNA, the Subcommittee on Training meetings and the mental health grant bursaries all played a role in the development of the psychiatric nursing specialty for registered nurses and assisted the western provinces' psychiatric nurses to become RNs. He noted that he was particularly proud of helping the western psychiatric nurses qualify for registration.[233]

Perhaps after his departure from the federal government Roberts was unaware of the curriculum committee's fruitless work on the combined program for the western psychiatric hospitals' training schools. Just as the Subcommittee on Training's work took

on a life of its own, so too did the work of its successor. Evelyn Mallory's 1956 progress report to the Advisory Committee on Mental Health explained that the curriculum committee had expanded to an interdisciplinary group of twenty members, most of whom were professors at the University of British Columbia (UBC). Eighteen meetings had been held.[234] She noted:

> Though accomplishment at this date may appear to be almost negligible...the committee has been striving to establish mutual confidence on the part of the psychiatric nurses and registered nurses, a slow process but one in which we believe some progress has been made....[We are]taking a fresh approach to the construction of a new curriculum....It is advisable to make haste slowly. We are approaching agreement on objectives.[235]

Mallory's report was accepted and endorsed by the Advisory Committee on Mental Health, as well as by delegates attending the CNA's biennial meeting and the Canadian Council of Psychiatric Nurses.[236] However, in the following two years key members resigned, including Lorna Horwood, a nursing professor at UBC and Mallory's co-chairman, Edith Pullan, and Dr. Gee. Mallory was not able to find another UBC faculty member with the appropriate expertise and she herself was unable to devote more time to the project.[237] The work slowed to a crawl and in 1959 the curriculum committee was dissolved. Dorothy Percy met with a concerned and regretful Mallory in a final attempt to reactivate the committee but to no avail.[238] Percy later recalled that "fruition of this training scheme seemed as far away as it had ever been. It is hoped that an idea that has much to recommend it may at the right moment be realized".[239] However, that was the right moment to begin bringing separate psychiatric nursing education into general nursing education in Western Canada. All players were agreeable and at the table and federal funding was available. Although Percy stepped in, albeit late, perhaps if there had

been a federal government psychiatric nursing consultant leading the project, it might not have collapsed. The failure of this federally-sponsored pilot project in British Columbia was significant, for it meant an unintended continuation of the status quo for separate doctor controlled mental hospital training programs in the three westernmost provinces. This project's failure, together with the imposed halt in the psychiatrists' eastward movement of western style psychiatric nurse training at the Manitoba-Ontario border, signified a "parting at the crossroads" in Canadian education for psychiatric nursing.

Percy wrote that "considerable time throughout the 1950's was spent by the Mental Health Division looking at the registered nurse and the psychiatric nurse for mental hospital nursing".[240] "Looking at" mental hospital nursing was exactly what Roberts and his federal committees and subcommittees, along with the CNA's committees and subcommittees, had done for most of the decade. Many of the mangled plans for mental hospital nursing were driven by personal ambitions, private agendas, ideals and principles, and were neither realistic nor practical to implement at the federal or provincial levels. With 60,000 psychiatric patients in need of more and better nursing care,[241] the delay was unconscionable. Moreover, "looking at" the mental hospital nursing problem was consistent with Simmons' finding that, in spite of federal mental health grant monies, there was an overall weakness and in many cases even a failure in the development of post-war federal and provincial mental health policies and planning.[242]

Organized nursing at the national level became entangled in this formidable problem and was unable to help move education for psychiatric nursing forward at the provincial level. Late in the decade, the CNA's Executive Committee once again found

itself "lobbying the federal health ministry to provide residence accommodation for psychiatric nursing experience in all basic programmes".[243] As described in the next section, it was not surprising that throughout the decade Ontario, Manitoba and Saskatchewan remained at different stages in the development of mental hospital nursing.

Mental Hospital Nursing, Ontario

The Ontario government and the RNAO remained consistent in their approach to the province's mental hospital nursing needs, both internally and at the national level.[244] Their mental hospitals were to be staffed by RNs, trained either at the mental hospital schools or through affiliations and post-graduate courses. An Ontario government recruitment brochure described psychiatric nursing as "a specialty in nursing which requires an RN with specialized education and training...a challenging branch of the nursing profession".[245] Nursing assistance was provided by ward aides and attendants, with the government finally agreeing to offer the RNAO certified nursing assistant ten month course at its mental hospitals.[246]

The affiliation program for general students remained a central piece in the preparation of nurses for psychiatric hospital work. Each year, twelve hundred students or about seventy percent of all Ontario students affiliated to nine mental hospital training centres – Brockville, Kingston, Whitby, New Toronto, Hamilton, London, Queen Street, St. Thomas and the Toronto Psychiatric Hospital.[247] While the affiliation was to have become compulsory in 1951, the date for its implementation was deferred because of the perennial student accommodation problem. Instead, all schools offered it to students at least as an elective.[248] In 1955 Dorothy Dick, Director of the Ontario government's

Nursing Branch announced that even though more general hospital schools were demanding the affiliation, she had to temporarily refuse their requests. She wrote:

> We are limited by a shortage of residence space and not enough teachers with psychiatric nursing expertise. We are busy building patient accommodation and student residences are not a government priority. One building has been converted...hoped for more space next year.[249]

Instructors observed that once students overcame their initial fears about the affiliation, they were enthusiastic learners. One noted:

> The student who asked how many padded cells there are in the hospital gave us a peep into most students' expectations....We are hopeful that this will disappear when more is known about mental illness and when all Ontario students receive the psychiatric affiliation.[250]

In her report to the RNAO, Dorothy Riddell, Inspector of Training Schools for the province, pointed out that affiliating students, while keen, were often critical of the mental hospital environments and their lack of resources for providing basic care. For example, they mentioned that there were not enough wash cloths to bathe patients, only one comb for a ward of women, no privacy for grooming, and few activities available to occupy the majority of patients. However, she was optimistic that as more general hospitals added psychiatric wards, schools of nursing would become less reliant upon the provincial mental hospitals for the psychiatric experience. Remarkably, she observed that some general hospitals were constructing psychiatric wards for the direct purpose of providing this clinical experience at the home schools.[251]

The second route which supplied mental hospital nurses, and the model chosen by the federally-sponsored British Columbia curriculum committee, the government's beloved combined training schools, was slowly disappearing. The schools at the Ontario Hospitals, London and New Toronto closed early in the decade and Hamilton graduated

its final class in 1953, citing a declining enrollment and lack of residence space.[252] A colourful recruitment brochure for the remaining three schools–Brockville, Kingston and Whitby–described attractive residences with free room and board, uniforms, laundry, tuition and medical care, a 44 hour week, three weeks vacation and monthly allowances of $30.00 (first year), $25.00 (second year) and $50.00 (third year).[253] Several students from one school told a Toronto newspaper that the monthly allowance was what enabled them to study nursing. Their families' financial situations were such that it was an impossibility to train at general hospital schools.[254]

With just three schools remaining, Dorothy Dick asserted her concerns to Dr. Phair, Deputy Health Minister:

> In spite of the growing opinion amongst nurse educationists that the basic course should be general rather than special, the Ontario nursing profession has kept faith over the past 33 years with the first Council of Nurse Education policy. In spite of commendable efforts of the Mental Health Branch to affect (sic) improvements, our three training schools are amongst the most impoverished in the Province–in hospital facilities, residences, curriculum and staff. The schools are a discredit to the Department of Health. There are questions to be considered:
> 1. Is it timely for the Department to discontinue basic nursing education?
> 2. Can the program be changed to incorporate new nursing education principles?
> 3. Would such a course attract more young women?
>
> These recommendations are therefore submitted:
> 1. The Department should establish one central autonomous school of nursing in the locale of a mental hospital and university.
> 2. The director of the school should be responsible to the Deputy Minister.
> 3. The school should accommodate 50 to 75 students per class.
> 4. Offer financial aid for student nurses to live in the community.[255]

While Dick advocated a separation of education from service and from the medical superintendents' control, her recommendation to collapse the schools and centralize them was not much different than what the committee of nurse leaders had recommended to

the provincial Mental Health Division and its medical superintendents eight years earlier.[256] Although she was the most senior nurse in the Ontario government's Health Department, Dick was omitted from the decision-making process. She was told only that her concerns would be discussed with the department's physicians.[257] No doubt her creative recommendations for educating students for psychiatric nursing would have been considered groundbreaking, even by most general hospital schools of the day. The three remaining schools were not centralized, and operated until diploma nursing education in Ontario moved to the community colleges in the early 1970's.[258]

As Dick pointed out, the Council of Nurse Education and the RNAO had recognized the Ontario Hospitals' schools of nursing for over three decades. Over 300 of the mental hospitals' 500 RNs were graduates of the Ontario Hospitals' training schools.[259] They had once been jewels in the province's mental hospital system, but a historical lack of nursing administrative authority and inadequate government spending had left them tarnished. Psychiatric affiliations for general students had become the norm in Ontario, but the distinct boundary between general and mental hospitals meant that even those were not yet under the control of nursing education.

Mental Hospital Nursing, Manitoba

The new 3½ year combined course offered between the Brandon Mental and Brandon General hospitals was thriving, with 52 students enrolled in 1952. The students referred to the Brandon General as "our sister hospital".[260] That year saw only four students in the separate two-year mental nursing diploma program, and Dr. Stuart Schultz, Medical Superintendent, reported to government that "the trend now is for the

combined course".[261] The only dissenting voice came from the MARN Board which believed that it was too long and costly for students and instead advocated one consistent training program for the three mental hospital schools in Manitoba. Rather than RNs or mental nurses, the Board preferred licensed practical nurses (LPN) or trained psychiatric aides.[262]

Ironically, the success of the combined program led to its eventual demise. With the increased emphasis on education, Schultz was short of student labour at certain times of the year. And because mental hospital students were hired into established civil service positions, Schultz was not able to hire more ward staff to replace those students in classes. He called on his brother, Health Minister Ivan Schultz, for help:

> It is impossible for me to keep on going with our combined course. I need some budgetary flexibility and other changes are needed. This requires help from Cabinet and the Civil Service Commission.[263]

Within a few months there was a cabinet shuffle and Minister Schultz was replaced by Dr. L. Bell. Dr. Stuart Schultz's appeal for help with his combined program went unheeded; instead the three mental hospital superintendents were advised by Health Minister Bell and Dr. Pincock that there needed to be a consistent training course for non-registered staff offered across the three institutions.[264] It is not known if the MARN's demand for change in mental hospital training had any influence on this decision. However, as a member of the federal Advisory Committee on Mental Health, Dr. Pincock attended the meetings in which his colleagues discussed the need for a standard auxiliary course across the country. Perhaps, then, he realized that his own province's mental hospital courses first needed standardizing.[265]

The decision was made to offer female students a thirty-month course which included a four-month practical nursing component taken at rural general hospitals. Dr. Schultz said that potential students needed an enticement to enroll, that is, being allowed to work as licensed practical nurses in general hospitals upon graduation. Even though the course was developed by psychiatrists and did not involve RNs, the MARN Board liked the plan.[266] The new course replaced the former two-year diploma in mental nursing, and the popular combined course disappeared in 1957 when its final students graduated.[267] With its demise and the move to a province-wide mental hospital training program, Manitoba's mental hospital nursing programs were starting to resemble those of its neighbors to the west, albeit with a few quirks–the practical nursing component, the continuation of the separate and less intense course for men, and the absence of an association and legislation.[268]

The MARN Board continued to show a lack of leadership concerning psychiatric affiliations for its general hospital students and in 1953 missed a perfect opportunity to take some control over the service-driven general hospital schools and gain some visibility in psychiatric nursing. The MARN Act was undergoing revisions and Drs. Pincock and Elliot, Deputy Minister of Health, requested that the psychiatric nursing affiliation be required for registration as an alternative to tuberculosis nursing.[269] Pincock had been trying for several years to get more affiliations established at the two mental hospitals and with the Act opened, the government saw an opportunity. Further, mental nurses in Manitoba were not organized or legally recognized, a situation which left the door wide open for registered nurses.[270] However, the Board was not interested because such affiliations were seen as "premature" and it believed that it would not be able to

obtain the support of the province's general hospitals' boards during the legislative session, thereby jeopardizing passage of the Act. The Board noted that the general hospitals were dependent upon student service and it would mean a major adjustment to their training programs. It was also concerned with the lack of facilities and resources at the Brandon and Selkirk mental hospitals.[271] Rather than taking the lead, it retreated from the issue, noting: "It is going to be required across the country in a few years and then the hospitals and schools will have to show greater support for the psychiatric affiliation".[272] Perhaps stronger leadership might have seized this opportunity to negotiate with the government for the needed resources at its two mental hospitals. In Manitoba the heavy service requirement by student nurses was an ongoing issue for the MARN, but it was not willing to force the issue for psychiatric affiliations. Instead, psychiatric affiliations for student education and mental hospital patient service were sacrificed in order to obtain timely legislation. Undoubtedly, the MARN's refusal to become involved in psychiatric affiliations had some bearing on the government's decision to initiate the province-wide mental hospital training program a few months later. [273]

A new minimum curriculum included a six to twelve week psychiatric clinical experience as "optional but strongly recommended". However, without MARN leadership, "strongly recommended" was not convincing to service-centered Manitoba schools, at least compared to the demand for affiliations by Ontario schools.[274] It was another four years, and at the recommendation of the CNA, before the MARN's nursing education committee, school directors, Dr. Pincock and Deputy Health Minister Dr. M. Elliot finally met to discuss the dual affiliation problems of residence space and lack of trained instructors at the province's two mental hospitals.[275] Further, without more

affiliations, and with the demise of Brandon's combined program, the number of RNs practising in psychiatric nursing in Manitoba was stagnant at thirty-two.[276]

Mental Hospital Nursing, Saskatchewan

Less than a year after Kathleen Ellis retired, members of the SRNA contacted Lola Wilson, the association's new Registrar, about rumours that the Saskatchewan Psychiatric Nurses Association was poised to ask the legislature to add the term "registered" to their title.[277] An angry Wilson contacted Ellis and met with the SRNA's legal counsel, and, in a move to prevent the title change, appealed to Dr. Fred Mott, Deputy Minister, Public Health.[278] Wilson offered reasons as to why the government should not support the title change:

1. In the Psychiatric Nurses Act the terms registered and registrar are used. Careful study of these terms reveals they are used in a very different context than in a title.
2. The use of the term nurse by the psychiatric worker was questioned in no small way by the SRNA and many in the field of psychiatry when the Act was presented in 1948. One of the strongest arguments brought forth by those who supported the term nurse was that the new title did not conflict with the title registered nurse. If the term registered is now added, it will conflict with our title.
3. In the United States and Canada a psychiatric nurse means an RN with courses and experience in this branch of nursing.
4. Some Saskatchewan psychiatric nurses already believe that they are qualified for general nursing jobs.[279]

The SRNA lobby effort was for naught. Vowles discovered that instead of having to go through the legislature the title change could simply be negotiated between their hospital union and government, because all union agreements were accepted by order-in-council.[280] A new agreement thus recognized that those psychiatric nurses who registered with their association were entitled to use the term "registered".[281] Vowles desperately

wanted that elusive designation and it was perceived as another huge victory for the fledgling nurses' association.[282] Its sister association in British Columbia, for example, had only been able to negotiate the use of the term "licensed".[283] In further attempts to emulate registered nurses the association initiated the traditional general hospital capping ceremonies at the province's three mental hospital training schools and adapted a pharmaceutical association pledge as their own.[284]

In spite of the steps toward professionalization, the new association continued to be strongly influenced by its union roots. For instance, association members wanted their union president to have access to the results of their final examinations; hence the union and government negotiated an agreement requiring the medical superintendents to forward examination results to the union president.[285] An administrator at the government's Psychiatric Services Branch observed that while patient care had shown improvement under the new psychiatric nurse training program, some of the teachers were not qualified to teach–they had won teaching positions through their seniority within the union.[286] He advised that:

> The Saskatchewan psychiatric nursing profession must awaken itself to the fact that it needs to be much more concerned with professional and educational issues. So far it has focused only on labor issues such as hours of work and seniority.[287]

Public Health Minister Bentley was informed that there was difficulty fitting the psychiatric nursing lectures into the students' salaried work schedules. He responded:

> Hindsight would indicate that it might have been better if we offered regular nurse training schools at the mental hospitals but the precedent has already been established. Maybe in time the psychiatric nurses will themselves realize this and make a change. But right now we have agreeable relations with their union.[288]

Although Bentley's comment was made just a few years after initiation of the new training program, he was questioning the apprenticeship or worker focus as opposed to the traditional general hospital service model of nurse training in which students were not on the payroll. However, McKerracher and the CCF Government specifically chose that model of training for Saskatchewan's mental hospitals and it was highly unlikely that the government or its psychiatric nurses wanted it changed. McKerracher and the Saskatchewan Psychiatric Nurses Association had, after all, effectively resisted both of the federal government proposals, one for the shorter psychiatric aide program and the other for the combined program.[289]

While Saskatchewan psychiatric nurses rejected federal government proposals to change their training program, they too experienced rejection at the hands of the CNA. National nurse leaders had declared that Western Canada's psychiatric nurses could not ever be considered a national body.[290] McKerracher, Gee and the Canadian Council of Psychiatric Nurses' lobby had convinced Dr. Roberts "to go national" with the western style psychiatric nurse training program and that plan took centre stage in Ottawa for over a year.[291] McKerracher's mission had almost been realized when he left the provincial government and mental hospital administration and moved into academia and general hospital psychiatry at the University of Saskatchewan. He lost interest in large mental hospitals and no longer had such a vested interest in the mental hospital training program which he had created.[292] As he advised them to do, his nurses retreated and focused on developing their separate and distinct profession within the boundaries of their own province.[293] A decade after McKerracher's dream died, Vowles reflected:

> I realize that a few of our members are disappointed because they cannot move across the Nation and work, but after all, their diploma is a

> Saskatchewan Government diploma. This government has, at no small cost, trained mental hospital nurses. The first duty of this association is to retain its members in Saskatchewan. This government should not make any provisions for them to leave the province and work elsewhere.[294]

This parochial view about the Saskatchewan psychiatric nurse training program was evidence that the psychiatric nurses' association had simply followed McKerracher's lead onto the national scene but did not aspire to see that training offered on a national level. The training remained hospital-specific and apprentice-oriented.

Three Months or Nothing

Besides the conflict which the SRNA had with the province's psychiatric nurses concerning their professional designation, the association fought with Dr. McKerracher over the length of the affiliation for the province's general students.[295] With the new psychiatric nurse training program firmly entrenched at the three mental hospitals, general students continued to have only the small Munroe Wing at the Regina General Hospital available for affiliations. Seven general hospital schools had been sending select students for a two-month affiliation, meaning about one hundred of the province's student nurses received the experience annually.[296] It was all that the SRNA had available; but without warning Lola Wilson was notified by McKerracher that he was increasing the length of the affiliation to three months, which meant only eighty students would receive the experience.[297] Stunned, Wilson requested details from McKerracher:

> What is the rationale? What is the need? What is the increase in content and practical work? Will more shift supervisors be available for our students?[298]

Dr. Fred Mott, Deputy Minister of Public Health advised Wilson that Dr. McKerracher was increasing the affiliation because the American Psychiatric Association (APA) did

not recognize anything less than three months for training school accreditation purposes.[299] Without local psychiatric nursing expertise or a federal psychiatric nurse consultant, Wilson reached out to former colleagues in Ontario for information about the APA requirement. Three directors of nursing advised her that their schools offered twelve-week affiliations but that it had nothing to do with psychiatrists or APA requirements; rather it was triggered by provincial nurse registration requirements and "our opinion has come from educators and leaders in psychiatric nursing in Ontario– Nettie Fidler, Edith Dick, Hilda Bennett".[300] Fidler, skeptical of McKerracher's new requirement, suggested it was service-driven and advised Wilson that two months for a greater number of students made better sense.[301] With the Ontario advice in hand, an assertive Wilson advised Mott that the directors of schools of nursing were concerned that their students were supplying only service during their night shifts at the Munroe Institute and requested a delay of one year. Wilson and the directors were hopeful that other affiliation facilities would be found.[302] Deputy Minister Mott appealed to McKerracher who declared that affiliations were to be "three months or nothing" and offered only a short reprieve.[303] Wilson was angry and frustrated by McKerracher's extensive control over psychiatric nursing education in Saskatchewan,[304] but nonetheless cautioned the directors that "we would do well to remind ourselves that if we lose our only psychiatric nursing affiliation it will be a severe blow to nursing education in Saskatchewan".[305] Contrary to the MARN, the SRNA supported the psychiatric nursing affiliation and wanted it made compulsory.[306]

With their hands tied, the schools sent their students for the longer affiliation. However there were complaints from students about four week stints of evening and

night shifts, often without a registered nurse on duty.[307] Fed up, the directors of schools of nursing advised the SRNA that they wanted nothing more to do with the three month service-driven affiliation and that if it was not changed back to two months, they would terminate the affiliation program with the Munroe Institute.[308] With only three registered nurses on staff at this facility, the twenty affiliating students provided the majority of the patient care and McKerracher would have been in a bind if their services were withdrawn.[309] Defensively, he explained to Deputy Minister F. Roth that the directors had not yet forgiven him for adding the four weeks and advised that since the students did not contribute much to the functioning of the wards, they would not be missed.[310] However, as was typical of McKerracher's behaviour pattern, he sent Elsie Ogilvie an urgent letter describing the potential demise of the affiliation program as a crisis for his hospital.[311] Ogilvie and McKerracher had a history of disagreeing on the topic of psychiatric nursing education, but as the Nurse Consultant for the APA, Ogilvie was perceived by McKerracher as a nurse with prestige and some authority whom he could use to justify his three month affiliation.[312] Further, Ogilvie had a special interest in affiliations for general students.[313] He told her that student nurses required the extra four weeks to grasp the methods of providing emotional care.[314] The directors of the schools of nursing, on the other hand, believed that McKerracher wanted their students for an extra four weeks of more proficient service.[315] His eloquent plea for help tugged at Ogilvie's heartstrings and, just as others had been before her, she too was manipulated by this powerful and personable psychiatrist. They agreed to meet in St. Louis, Missouri at an APA meeting and Ogilvie flew back to Saskatchewan with McKerracher specifically to meet with the school directors.[316]

While she assessed that better ward teaching on evening and night shifts was required at the Munroe Institute, Ogilvie delivered the same message: the APA required a twelve week affiliation for school accreditation. She offered surprisingly little understanding of the SRNA's predicament that fewer students received the longer affiliation. Rather, she was on a mission to "sell" the twelve-week affiliation for McKerracher.[317] Unlike the Ontario nurse educators, none of the directors challenged the decision to adopt the APA's affiliation criteria for Saskatchewan; and further, they were unaware that the Munroe Institute had never even applied for APA accreditation or that there was a move to end the APA accreditation service in the United States.[318] Saskatchewan's nursing profession did not have many registered nurses with psychiatric nursing expertise and the educators therefore were dependent on external advice.[319] McKerracher was ecstatic when the decision was made by the educators to continue with the three-month affiliation. Ogilvie's meeting with "the good ladies" had worked just as planned.[320] However, in spite of their compliance the directors and the SRNA were adamant that other ways for providing the psychiatric affiliation had to be found. They were hopeful that general hospital psychiatric wards, when developed, would solve the affiliation problem for Saskatchewan.[321]

The formidable struggle to obtain psychiatric affiliations for Saskatchewan students was not unlike that which Kathleen Ellis experienced fifteen years earlier with McKerracher's predecessor, Dr. James MacNeill. At that time MacNeill insisted that Ellis needed to send general students on one-year mental hospital affiliations. Ellis refused and general students were shut out of Saskatchewan's mental hospitals, just as they continued to be in 1955.[322]

These three provincial nurses' associations each had a different problem with mental hospital affiliations: Ontario mental hospitals did not have enough residence space for the high affiliation demand; Manitoba hospital boards did not want to lose students' service to mental hospitals and nursing leadership chose not to get involved; and most Saskatchewan students could not obtain this affiliation experience in spite of committed leadership. The common issue for all three associations was their ongoing lack of control over this nursing education experience. Until that control was obtained and mental hospital affiliations became commonplace, nurses were needed. The final section of this chapter describes how one nurse influenced a solution for the western provinces.

In Certain Provinces These Might Develop Along Parallel Lines

Apart from the affiliation issue for general students, it was clear that Ontario, Manitoba and Saskatchewan remained at different stages in the development of mental hospital nursing. Ontario and Saskatchewan represented the dichotomy that plagued psychiatric nursing in Canada. In Ontario the term meant a specialty of general nursing, whereas in Saskatchewan it signified a newly legislated and distinct nursing profession. Probably nobody better understood the intricacies of this situation than Canada's Chief Nursing Consultant, Dorothy Percy. While she initially was influenced by Roberts' psychiatric authority and unabashedly favoured the adoption of the western training system for all of Canada, by the end of her first year her perspective shifted. The change may have been related to her personal development in the new position and to her increased knowledge of education for psychiatric nursing.[323] Once she arrived at an informed decision about the unacceptability of the western-style psychiatric nursing

program for the eastern provinces, she felt obliged to "broaden and deepen my appreciation of the country's mental hospital nursing field"[324] through travel, attendance at American psychiatric nursing meetings and even speeches on the topic. For example, Percy made these observations to an AARN annual meeting:

> My distinct impressions upon returning from a recent trip is that of a rapidly growing interest in psychiatric nursing by students still in school to working registered nurses. This growing interest is not without significance....Surely this enormous, challenging field is too large and complex for any one group to stake out rights. For better or worse, the walls are down, the doors are opening...psychiatric nursing is becoming all-embracing and in time it will quietly set the standards for all nursing. Forty general hospitals now have psychiatric wards which require competent psychiatric nurses. However gaps remain–outdated curricula, heart breaking shortages of registered nurses, a tragic lack of funds, antiquated institutions and overcrowding.[325]

Perhaps the strongest evidence of the growth in her leadership and confidence in the psychiatric nursing education issue appeared in a rebuttal to a paper written for psychiatrists by Dr. Sam Lawson, McKerracher's successor in Saskatchewan. Lawson wrote:

> It will take ten years to get enough RNs for our mental hospitals and therefore a compromise has to be made with this professional ideal. The only solution is for us to train a new group of staff to replace RNs at Canadian mental hospitals. Psychiatric hospitals can train people to perform the duties they want performed and can inculcate the correct habits and attitudes....The content of the course can be practical, without reference to prestige and empire building of the general nursing profession.[326]

The curriculum committee under Mallory was still active and Percy was hopeful that, in time, the combined curriculum for the western mental hospitals would offer students an improved training. Further, Percy was acutely aware of the expansion of general hospital psychiatry–150 registered nurses attended a conference on "psychiatric nursing in general

hospitals",[327] for example and Lawson was talking about replacing them with less qualified workers. Percy took issue with Lawson's rhetoric and authority:

> I deplore this violent attack on the nursing profession...many demands made upon it by doctors, hospitals and governments, all of whom expect the nurse to do what they think she should be doing....This writer is indulging in an "either or" attitude for mental hospital nursing. Instead of "either or" we need to think in terms of a variety of training, and for the time being, in certain provinces, these might develop along parallel lines. And we need to quickly press ahead with the proposed combined course for the west. The care of the mentally ill is too big for any one group and too important to disrupt by such jealousies and competition....It is my belief that psychiatric nursing may well take us forward to a better kind of nursing for all our patients.[328]

Taken together, these papers revealed conflicting views about education for psychiatric nursing. Many medical superintendents saw it as a specialized apprenticeship which provided service to the hospital. Nurse leaders, on the other hand, viewed it as one component of general nursing education. The two papers remained CMHA background papers,[329] but nonetheless Percy's words reflected the thinking of Canada's Chief Nursing Consultant in 1957. Above all, she was advocating better care for both psychiatric and general patients and arguing that nurses, not others, were responsible for nursing matters. She appreciated that psychiatric nursing was at a markedly different stage of development in Western Canada and endorsed, for those provinces at that time, a pragmatic continuation of both models of education for psychiatric nursing. Percy was not considered a leader in Canadian psychiatric nursing, nor did she consider herself as such;[330] but the evidence showed that in her role as Canada's Chief Nursing Consultant, she influenced the parallel development of the two models for Western Canada.[331]

Conclusion

Bracketed by Elsie Ogilvie's presentation to the federal government's Mental Health Advisory Committee on recommendations for improving mental hospital nursing, and some assertive advocacy by a handful of nurse leaders around education issues, the years between 1947 and 1955 were critical ones in the development of education for psychiatric nursing.[332] For the first time education for psychiatric nursing moved onto the national scene, and was addressed by both the federal government and organized nursing. Struggles between nursing leadership and medical psychiatry for control of education for psychiatric nursing at the provincial level escalated into a battle at the national level.

Canada is a federation of regions with diverse needs and interests and it was probably unrealistic for the provincial directors of mental health on the federal Advisory Committee to pursue the idea of a country-wide standardized training program for mental hospital auxiliary staff.[333] The mandate of the federal government's Mental Health Division was to provide leadership around policy and consultation to the provinces.[334] Thus if Elsie Ogilvie or some other psychiatric nurse leader had been made available to assist the provinces, and Drs. McKerracher, Gee and Roberts had not hijacked the federal agenda, an auxiliary training course might have developed in some provinces. That the concept was switched, with federal government endorsement, from a twelve-month auxiliary course to a three-year psychiatric nurse training program was astonishing, and indicative of what Simmons found to be an ineffective division of government.[335] It revealed a process driven by ambitious and powerful personalities, political maneuvering and, in some instances, indiscretions by government-appointed psychiatrists. Long-standing psychiatric authority and paternalistic behaviours were transferred from the

male-dominated mental hospital culture to new work milieus and relationships.[336] In his autobiography, Roberts lamented the erosion of the medical profession's power over the four decades in which he practised, and the concomitant increase in nursing's control over hospital care. He wrote:

> How could physicians, with the prestige and social standing their education confers on them, who perform such extraordinary feats...how could they lose power within their institutions? Physicians must regain control of hospitals and win back the power they once wielded.[337]

Save for a non-enforceable course in the *CNA's Proposed Curriculum for Schools of Nursing in Canada*, the education for psychiatric nursing had not received any attention by organized nursing at the national level.[338] For the first half of the twentieth century the CNA leadership had been concerned with registration and education issues and had no presence in psychiatric nursing. That the CMHA, a voluntary association, was perceived by the federal government as more credible in the area of education for psychiatric nursing than the CNA, was telling.[339]

Education for psychiatric nursing was creating problems in Western Canada and fell onto nursing's national agenda as a result of Edith Pullan's leadership.[340] However, political naiveté; limitations of gender that were rooted in the power of males and the weakness of females in contemporary society; and a lack of authority especially in relation to the extremely powerful psychiatrists and federal government, saw Canadian nurses come perilously close to losing all control over education for psychiatric nursing. This was well-illustrated at the CNA's 1954 biennial meeting, the "battle at Banff", when hundreds of nurses did not outwardly protest Roberts' paternalistic suggestion for educating a new separate group of psychiatric nurses; nor did they rally behind Elizabeth Bregg's warning of disaster to the specialty's development and her call for action.[341] As a

group they were silent and deferential, supporting McPherson's finding that relations between Canadian nurses and physicians throughout the 1950's were defined by authority, respect, paternalism and deference.[342] But despite such attitudes and behaviours, there was success. It fell upon a handful of well-educated, assertive psychiatric hospital nursing directors and educators, along with the country's Chief Nursing Consultant, to crack the monopoly on education for psychiatric nursing held by medical psychiatry. They determined that the solutions arrived at by psychiatrists for the separate education of psychiatric nurses in Saskatchewan, Alberta and British Columbia were not appropriate for the whole country.[343] The turning point and hence demise of the distinct Western Canadian psychiatric nursing education movement as a national standard occurred at two meetings in Ottawa and Vancouver in late 1954 and early 1955.[344]

The victory by nursing's leadership at the national level was somewhat hollow, however, for educators in Saskatchewan, Manitoba and Ontario continued to have minimal or no control over education for psychiatric nursing for their students. For the most part that education was located in the geographically distant and culturally distinct psychiatrically-administered provincial mental hospitals. The three provincial nurses' associations were unable or unwilling to mandate and examine psychiatric nursing until all students received an equal opportunity for the affiliation. Characteristics of mental hospitals and general hospital training programs made that an impossibility. Although the CNA recommended the affiliation to its member associations, its role was advisory.[345]

Significantly, the nurse leaders' success at halting the psychiatrist-driven separate nursing education movement at the Manitoba-Ontario border meant that what had once threatened to become a national problem for organized nursing remained an issue for

only the country's three westernmost nurses' associations. Manitoba bridged the two regions, tilting first to the east and then the west. Mental nurses in that province remained unorganized and were without legal recognition,[346] and further, Brandon's once popular combined program had been transformed into a course which only slightly resembled those of its western counterparts. The finding that Manitoba psychiatric nurses were not part of the western psychiatric nursing picture in the mid-1950's differs from Dooley's findings. He showed that Brandon's combined program contributed to mental nursing's distinct occupational identity, and suggested that this identity then played a role in the creation and adherence to the separate and distinct training system in Western Canada.[347]

Under Percy's influence, both models of education for psychiatric nursing – separate and specialty–remained in Western Canada, and were poised to develop along parallel lines, albeit temporarily.[348] Bregg warned that the arrival of the separate and distinct western psychiatric nurses foreshadowed disaster for the specialty of psychiatric nursing in Canada. While the time period for this study did not allow for exploration of her prediction, a decade later the editor of *The Canadian Nurse* called for an end to the silence and for an examination of the western registered psychiatric nurse issue. Nurse leaders in the western provinces were concerned that the new doctor-controlled education program was not adequately preparing western psychiatric nurses to provide quality psychiatric patient care.[349]

Organized nursing in Canada was not alone in the 1950's battle to gain control of education for psychiatric nursing. Nolan described a similar conflict between Britain's General Nursing Council (GNC) and the country's medical superintendents and their professional association, the Royal Medico-Psychological Association (RMPA). In 1951,

however, the GNC took over responsibility for mental nursing education and examinations from the psychiatrists. Mental nursing education was modeled on general nursing education programs of the day.[350] The distinguishing feature was that mental nursing education remained separate, at the mental hospitals. Nolan reported that the medical superintendents "openly resented" the GNC and its school visitors, as a result of the superintendents' loss of control of mental nursing education.[351]

Not unlike the move to bring Western Canada's mental hospital training programs into general nursing education, British nurse leaders also recommended bringing mental nursing under general nursing's umbrella. Nolan showed that the recommendation was driven by a desire by organized nursing to encourage middle class females to train as mental nurses. The recommendation saw no action.[352]

In her study on the development of the psychiatric nursing discipline in the United States, Church found that through the war and post-war years organized nursing and the APA collaborated well on education for psychiatric nursing.[353] That cooperative spirit continued into the 1950's, save for the issue of accreditation of mental hospital training schools. There were 71 schools and the APA and its medical superintendents were reluctant to hand over accreditation responsibility to the National League for Nursing Education (NLNE) because of a perception that the use of the NLNE's more stringent criteria could mean some schools would lose their standing and therefore student service.[354] After several years of negotiations and numerous meetings between the two groups, the APA, perceiving that accreditation of schools of nursing truly belonged with nursing, relinquished its accreditation program.[355]

Church's findings revealed that while the NLNE's takeover of accreditation responsibility was an important step in the development of psychiatric nursing education,[356] even more critical was the passage of the federal government's National Mental Health Act. During the war years, American citizens became distressed with new information about the overcrowded state mental hospital systems, and the Bill was an attempt to break the hold which the state hospitals and their medical superintendents had on the country's mental health care system.[357] Community care was promoted and hand-in-hand with this changed focus, funds were provided for health professional education in the form of fellowships and grants to universities to establish new education programs. New post-diploma and graduate programs in psychiatric nursing were established and undergraduate programs received funds to develop psychiatric nursing courses.[358] Church reported that this federal government intervention was welcomed by organized nursing for it allowed over 2,000 nurses to study psychiatric nursing at American universities during the 1950's.[359] She analyzed this move to higher education as "the turning point in the development of the discipline".[360] Nurse educators with graduate preparation in psychiatric nursing took over education responsibilities from psychiatrists, and as new settings were developed the mental hospitals and doctors began to lose the monopoly which they had traditionally held over nursing education and practise.[361]

Simmons' findings revealed that what transpired in the United States during the 1950's as a result of the National Mental Health Act contrasted with the situation in Canada, and the two countries' mental health policies headed in opposite directions.[362] The American mental health policy movement was national in scope, community and mental health (non-mental hospital) orientated and multidisciplinary in composition,

including nurses.[363] In Canada, the small Mental Health Division and its fifteen man Mental Health Advisory Committee, all psychiatrists, set policy and distributed mental health grant funding.[364] Simmons suggested that the division was ineffective and that its Advisory Committee had minimal influence on specific policy creation.[365] The majority of grants went to additional beds at the psychiatrists' provincial mental hospitals and to new general hospital psychiatric wards. Within a short period Canada had ten times more institutional beds on a per capita ratio than its southern neighbour.[366] Simmons attributed the psychiatrist-controlled and mental hospital-centered policy in Canada to vested interests, lack of federal funding and accountability for funding decisions, internal conflict, and a lack of educated mental health professionals, other than psychiatrists. As a result, most Advisory Committee recommendations saw little action, either nationally or provincially.[367]

As the findings from the current study have shown, the development of education for psychiatric nursing was negatively affected by the problems within the federal Mental Health Division and its Advisory Committee, and did not reflect the American psychiatric nursing situation, particularly around locus, control and type of nursing education.[368] For example, while 428 Canadian registered nurses received mental health grant monies for further education, the courses at the University of Toronto and McGill University were certificate, non-degree courses and not popular.[369] And while nurse leaders successfully blocked the western psychiatrists' attempt to extend their monopoly on psychiatric nursing education eastward, the majority of education for psychiatric nursing remained at provincial mental hospitals, was service-driven and tightly controlled by those psychiatrists. While the leaders cracked the doctors' monopoly, they did not

break it. Church demonstrated that until the doctors' monopoly was broken, American psychiatric nursing education and practise developed slowly.[370] Canadian nurse leaders instead pinned their hopes on another locus–the expansion of general hospital psychiatric wards. In spite of the astonishing amount of attention given to it at the national level from 1947 to 1955, and just as education for psychiatric nursing was moving into higher education in the United States, the provision of education for psychiatric nursing in Canada split along provincial boundaries into two models.

Notes

1. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947; RG29, Vol. 335, File 436-5-5, Pt.1, Mental Health Division, Nursing, Programme of the Mental Health Division, 1949.
2. NAC, RG29, Vol. 329, File 436-1-1, Pt.1, Mental Health Division, Marjorie Earl, "Canada Tackles Mental Disease", *The Toronto Star Weekly* (June 11 1949):11.
3. NAC, RG29, Vol. 314, File 435-6-1, Pt.1, Mental Health Division, Press Release, Mental Health Conference, Oct. 5, 1946. The new division along with its advisory committee took over from the voluntary efforts of the CMHA.
4. NAC, RG29, Vol. 314, File 435-6-1, Pt.2, Mental Health Div., Minutes of the First Federal-Provincial Conference of Mental Health Directors, Oct. 10-11, 1946.
5. NAC, RG29, Vol. 303, File 435-2-1, Mental Health Div., Progress in Mental Health, Chief, Mental Health Division, Feb., 1953. Also see Harvey Simmons, *Unbalanced: Mental Health Policy in Ontario, 1930-1989* (Toronto: Wall and Thompson, 1990), 87-88. Simmons described the elite of Canadian psychiatry who became committee members.
6. Ibid.
7. NAC, RG29, Vol. 315, File 435-6-2, Pt. 3, Advisory Committee on Mental Health, Points for Minister's Address at Advisory Committee on Mental Health, Oct. 25-26, 1948. Stogdill prepared these notes for the minister of National Health and Welfare.
8. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947, 1-2.
9. NAC, RG29, Vol. 332, File 436-2-5, Mental Health Div., Letter to Dr. J. Phair, Deputy Minister of Health, Ontario from Dr. G.D. Cameron, Deputy Minister of National Health, June 6, 1947. Cameron explained Ogilvie's work and qualifications.
10. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947.
11. APA Archives, Nursing, Box 1, Folder 19, Committee on Psychiatric Nursing, Minutes, 1953. She was telling the other committee members about Saskatchewan's new program.
12. AO, RG10-107-0-423, HS15-2, Container 65, Fitzsimmons Survey, 1943-44, "Survey of Nursing in the Ontario Hospitals", Spring, 1943.
13. AO, RG10-20-A-1, File 1.2, Superintendents Conferences, Minutes, 1945-49, Meeting Sept. 30, 1947. Fair presented the report from Ogilvie to Ontario's medical superintendents. Fair was a 1932 graduate of the Whitby training school (under Nettie Fidler) and had nursed overseas during the war. In 1946-7 she was employed as the MARN's executive secretary.

14. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Letter from Dr. Pincock to Dr. Jackson, Deputy Minister, Health.
15. NAC, RG29, Vol. 332, File 436-2-5, Pt.2, Mental Health Div., Nursing, Letter to Ogilvie from Elva Cranna, Jan. 22, 1948. Other letters in this file revealed that communication within some provincial mental health systems was weak.
16. SAB, R-11-14-19, 1944-52, Memo to T.C. Douglas from Dr. C. Hames, Deputy Minister Public Health re-attached minutes, May 7, 1947. Ogilvie and McKerracher were at this meeting in Weyburn, Saskatchewan.
17. NAC, RG29, Vol. 332, File 436-2-5, Mental Health Div., Nursing, Letter to Ogilvie from Sam Lawson, Dec. 10, 1947. Lawson meant the hospital union resisted having RNs on staff.
18. NAC, RG29, Vol. 332, File 436-2-5, Pt.2, Mental Health Div., Letter to Griffith from Stogdill, May 25, 1951.
19. Elsie Ogilvie, "Psychiatric Care Challenges Nursing", *The Canadian Nurse* (Dec. 1949):907-909.
20. NAC, RG29, Vol. 332, File 436-2-5, Pt.2, Mental Health Div., Nursing, Letter to Helen Gemeroy from Ogilvie, Sept. 10, 1947; Letter to Ogilvie from Ella Smith, Superintendent of Nurses, Ontario Hospital Kingston, Aug. 25, 1947. Letters exchanged between retired Vancouver General Hospital director of nursing Grace Fairley and Ogilvie centered on Fairley's work to institute a 4 year course in British Columbia. See letter to Ogilvie from Fairley, Feb. 9, 1948 and letter from Ogilvie to Fairley, Feb 12, 1948. This file contains numerous other letters in and out of Ogilvie's office.
21. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Minutes, Meeting Jan. 22-23, 1951. Also see AO, RG10-163-0-106, Container 3, Brochure "Psychiatric Nursing, A Growing Field", National Health and Welfare, Ottawa, 1950.
22. NAC, RG29, Vol. 335, File 436-5-5, Pt.1, Mental Health Div., Nursing, Letter to Miss Petry from Ogilvie, July 20, 1948; Letter to Ogilvie from Petry, July 27, 1948. American universities received government funding to develop graduate programs in psychiatric nursing.
23. Ibid; Elsie Ogilvie, "Psychiatric Care Challenges Nursing", *The Canadian Nurse* (Dec. 1949):907-909.
24. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Memo to Paul Martin, Minister from C. Stogdill re-mental health nursing consultant, Sept. 10, 1947; Vol. 325, File 435-10-5, Mental Health Advisory Committee Minutes, Meeting, Oct. 3-4, 1949. Ogilvie left Ottawa in the summer of 1948.
25. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Memo to Paul Martin, Minister from C. Stogdill re-mental health nursing consultant, Sept. 10, 1947. His original submission underwent many revisions.
26. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Memo to Minister Martin from G. Cameron, Deputy, Oct. 14, 1949.
27. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Letter to my dear colleagues from Paul Martin, Oct. 1949. This office copy does not have the specific date. Martin made a personal appeal, over and above the formal departmental submission. Also see Simmons, 87-90. Simmons noted that Canada did fall behind the USA.

28. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Letter to the Honourable Treasury Board, Submission #312, Health, from Paul Martin, Oct. 17, 1949. It was not clear whether "cancelled" came from within Martin's department or from the treasury board itself.
29. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Subcommittee on Training, 1954-58, Memo from Dorothy Percy to Dr. C. Roberts re-psychiatric nurse consultation, July 22, 1955. Percy was the new chief nursing consultant for the Canadian government and became involved in psychiatric nursing.
30. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health, Dominion-provincial conference on mental health, minutes, Oct. 1-3, 1947. McKerracher was the only one at this meeting who said anything negative about Ogilvie's report.
31. Paul Martin and Deputy Minister Cameron emphasized to the treasury board that a nursing consultant would not be interfering with provincial matters. McKerracher could have suggested that it was going to interfere with his Saskatchewan program.
32. Dorothy Percy, "Historical Aspects of the Role and Function of Nursing Services in the Department of National Health and Welfare", *Medical Services Journal Canada 23* (1967): 1461-1486. It was October, 1949 when the submission was cancelled.
33. Ibid. Percy pointed out that the health and welfare department's administrators were reluctant to create a permanent nursing consultant position so the same would likely have been true for the mental health position. Instead Percy was seconded on a part-time basis in 1949. Several years later Percy became involved in psychiatric nursing.
34. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Letter to my dear colleagues from Paul Martin, Oct. 1949.
35. NAC, RG29, Vol. 335, File 436-5-5, Pt.1, Mental Health Div., Nursing, Letter to E. Ogilvie from Lucille Petry, Chief Nursing Officer, United States Dept. of Public Health, July 27, 1948. Also see Olga Church, "That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963" (Ph.D. diss., University of Illinois, 1982).
36. NAC,RG29, Vol. 332, File 436-2-5, Pt.2, Mental Health Div., Nursing, Letter from Dr. Stogdill to Gertrude Hall, Secretary, CNA, Oct. 12, 1949. Stogdill and Hall decided that Ogilvie's work with the federal government was solid evidence for her nomination for this position. It is not known what transpired around this position. Hall was warned that the survey was confidential.
37. AHCPMH, CMHA, National Office Records, Minutes, Scientific Planning Council, Annual Meeting, 1952. Ogilvie left McGill for the APA in 1951.
38. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, Jan. 22-23, 1951.
39. Ibid. McKerracher also had not been happy with Ogilvie's report.
40. Ibid. Stogdill was evidently concerned about McKerracher's opposition.
41. Charles Roberts, *From Fishing Cove to Faculty Council...and Beyond* (Calgary: Pondhead Publishers, 1995), 71.
42. Ibid.
43. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, June 5-6, 1952.
44. Ibid. By then he had traveled to most of the provinces and read Ogilvie's report.
45. Ibid. Also see Olga Church, "That Noble Reform: The Emergence of Psychiatric

Nursing in the United States, 1882-1963" (Ph.d., diss., University of Illinois, 1982).
46. Ibid. For MacLean the issue was larger and more complex than the need for a mental hospital aide course. Although the new Alberta association was not under an Act of the legislature, its creation caused the AARN to write to the RNAO for advice. See RNAO Archives, Green Books, Minutes, 1950-51, Dec. 15, 1950 Board meeting.
47. Ibid.
48. Ibid.
49. Ibid. Marjorie Keyes of the CMHA had responsibility for nursing education.
50. Ibid. Dr. Griffin of the CMHA notified fellow committee members that the CMHA was concerned about psychiatric nursing education for RNs and had begun studying the issue.
51. WGH Alumnae Archives, Curricula, "A Proposed Curriculum for Schools of Nursing in Canada", Canadian Nurses Association, 1936, 91-95. Marjorie Keyes worked with Nettie Fidler, Dr. Farrar and Harriet Mitchell to develop this course.
52. Ibid.
53. AHCPMH, CMHA, National Office Records, Minutes, Scientific Planning Council, Annual Meeting, 1951. Keyes reported on her work to this meeting. The survey documents were not attached.
54. Ibid.
55. AHCPMH, CMHA, National Office Records, Minutes, Scientific Planning Council, Annual Meeting, Feb. 1952. Keyes' report was appended to the minutes.
56. Ibid.
57. Ibid.
58. Ibid. Keyes pointed out that the different environments were a critical factor and used the TPH as an example of a more modern psychiatric hospital.
59. Ibid.
60. Ibid. The original course was developed in 1936.
61. Ibid.
62. CNA Archives, Minutes of Executive Committee, 1952, Feb. 16. The resolution was read and approved without significant discussion.
63. RNAO Archives, 96C-2-13, "A Submission to the Provincial Deputy Ministers of Health with Respect to Nursing Service in Canada", CNA, Sept. 1947. The deputies and Dr. G. Cameron, Deputy Minister of National Health and Welfare met as a federal-provincial group. The second paper "Nursing Service in Canada", CNA, Sept. 1949 was presented to Dr. G. Cameron secondary to the health grants announcement.
64. NAC, RG29, Vol. 332, File 436-2-5, Mental Health Div., Nursing, Letter from E. Ogilvie to Gertrude Hall, March 25, 1947. Ogilvie traveled to Montreal to meet with Hall and gather information for the survey.
65. NAC, RG29, Vol. 1102, File 502-8-4, Civil Service Health Division, Report, CNA Biennial Meeting, June 26-30, from Dorothy Percy.
66. Ibid. It was noted that some nurses wondered how hospitals would staff their wards if all schools adopted the "Windsor School" model. Fidler explained "they pay for nursing service".
67. Ibid.
68. Percy, 1470-71. Percy noted that the federal government was reluctant to make this position permanent but she did not explain why. Prior to her position with the

federal government Percy served as a nursing sister during World War II. Before the war she studied and taught at the University of Toronto's school of nursing. See Glennis Zilm, "Looking Back, Dorothy Percy 1901-1992", in *Nursing Foundations, A Canadian Perspective* eds.B. Du Gas and E. Knor (Scarborough: Appleton & Lange, 1995), 188.

69. CNA Archives, Minutes of Executive Committee, 1951, Feb 8-10. Pullan had been attempting to develop a new curriculum for her hospital's non-registered staff when she came across the variation. She wanted the RNABC or CNA to set standards. Pullan was a recent BASc(N) graduate from UBC and took over the director of nursing position in 1951. Her concern about strained relations in BC was consistent to that raised by Alberta's Dr. R. MacLean to the mental health advisory committee a year later. See NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Advisory Committee Meeting Minutes, June 5-6, 1952.

70. Ibid. Lola Wilson, the SRNA's new registrar brought this information to the CNA executive committee. Kathleen Ellis had never done so.

71. CNA Archives, Minutes of Executive Committee, Nov. 2, 1951 and Feb. 14, 1952. The educational policy committee took over the project in preparation for June, 1952.

72. NAC, RG29, Vol. 335, File 436-5-5, Mental Health Div., Nursing, Letter from Dr. Chas Roberts to Miss G. Hall, Aug. 14, 1951.

73. NAC, RG29, Vol. 305, File 435-3-7, Mental Health Div., Letter to Dear Mac from Chas Roberts, Dec 8, 1951. Discussed the Canadian Football League teams, Ottawa, Regina and Mr. Dobbs.

74. NAC, RG29, Vol. 335, File 436-5-5, Mental Health Div., Nursing, Letter from Hall to Roberts, Sept. 21, 1951. She did not question his large request and apologized in advance for the time it would take.

75. NAC, RG29, Vol. 335, File 436-5-5, Mental Health Div., Nursing, Questionnaire "Information on Psychiatric Training for Nurses", CNA, Oct. 1951. The completed forms were later turned over to Roberts.

76. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, "Some Comments and Opinions Regarding Psychiatric Training Expressed by Provincial Nurses' Associations", March, 1952.

77. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, June 5-6, 1952. It was his first meeting when he told his colleagues that "the field was too confusing". He then had this feedback from the provincial nurses' associations and suggested use of Fitzsimmons' APA curriculum for mental hospital aides, and to leave psychiatric nursing affiliations in the hands of the CMHA.

78. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, "Some Comments and Opinions Regarding Psychiatric Training Expressed by Provincial Nurses' Associations", March, 1952.

79. NAC, RG29, Vol. 335, File 436-5-5, Mental Health Div., Nursing, Letter from Hall to Roberts, March 13, 1952. She sent the final questionnaires and mentioned that she would be pleased to discuss this matter. That discussion didn't take place for Hall left her CNA position.

80. There was no record of Hall's work for Roberts nor were the questionnaire results cited in any minutes. Perhaps Hall leaving at the same time was a factor.

81. CNA Archives, Annual Meeting Folios, 1912-1954, B2/1, Biennial Period, 1952-54. Resolutions passed June 6, 1952, Quebec City. The CMHA resolution on affiliations was endorsed by the CNA but it did not come forth from CNA members.
82. CNA Archives, Minutes of Executive Committee, Jan. 29, 1953. Evelyn Mallory, chairman of the educational policy committee and the person who was ultimately responsible for the project realized that the auxiliary worker and registered nurse training for mental hospital work could not be separated. Russell was thought to be the one who could make this project work.
83. WGH Alumnae Archives, Journal Collection, Evelyn Mallory, "The Preparation of Nursing Personnel for the Care of the Mentally Ill", *The Canadian Nurse* (Nov. 1954):869-878. One appointee was Marjorie Keyes of the CMHA and gradually this CNA project took over the CMHA's work on psychiatric nursing education for registered nurses.
84. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to Miss. P. Stiver from Dr. C. Roberts, Jan. 3, 1953. Roberts asked Stiver if anything further could be added to Hall's work because he wanted to use the data for the federal project.
85. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to Roberts from Pearl Stiver, Jan. 12, 1953; NAC, RG29, Vol. 1689, File 437-11-3, Pt. 1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, June 5-6, 1952.
86. CNA Archives, Minutes of Executive Committee, Jan. 29, 1953. Russell's earlier paper was titled "Report of the Special Committee to Study Auxiliary Nursing Personnel", 1952. Also see Annual Meeting Folios, 1912-54, Resolutions passed June 6, 1952.
87. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to Roberts from Pearl Stiver, Jan. 12, 1953.
88. NAC, RG29, Vol. 317, File 435-6-6, Pt. 1, Subcommittee on Training, Letter to Kemp from Roberts, Oct. 20, 1952. It took Roberts the summer and autumn of 1952 to arrange funding for Kemp's contract.
89. NAC, RG29, Vol. 317, File 435-6-6, Pt. 1, Subcommittee on Training, Letter to Kemp from Roberts, Nov. 14, 1952.
90. Ibid; Also see Letter to Roberts from Kemp, Oct. 28, 1952.
91. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter from Dr. A. Gee to Dr. Roberts, Feb. 6, 1953. Gee mentioned the Act which was an order-in-council creating the new two-year psychiatric nursing course and licensing in BC. British Columbia was the second province to enact legislation for psychiatric nurses.
92. CNA Archives, Minutes of Executive Committee, 1951, Feb. 8-10. Pullan developed the 2 year curriculum for the BC group but was concerned about the short course. Gee was not.
93. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Comments from the Provinces, Feb, 1953.
94. Ibid.
95. Ibid.
96. NAC, RG29, Vol. 317, File 435-6-4, Subcommittee on Training, Memorandum to the Subcommittee on Training of the Advisory Committee on Mental Health, from Edith Kemp, Feb. 22, 1953. As occurred in Saskatchewan aides and attendants in BC

were transformed into psychiatric nurses and the former category disappeared. This transformation was hastened by the new provincial legislation.
97. Ibid.
98. Ibid.
99. Ibid.
100. Ibid.
101. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Agenda, Meeting March 4-5, 1953.
102. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter from Dr. A. Gee to Dr. Roberts, Feb. 6, 1953.
103. NAC, RG29, Vol. 303, File 435-2-3, Mental Health Division, Memo to Dr. G. Cameron Deputy Minister from Roberts re-temporary mental health nurse consultant position, July 25, 1952.
104. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, "Comparison of Cost of Students Enrolled in Saskatchewan 3 Year Course with One Year Proposed Course", March 4, 1953.
105. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, "Report on the Subcommittee on Training to the Advisory Committee on Mental Health", draft, March 6, 1953.
106. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, "Recommendations from the Subcommittee", March 6, July 14, 1953 (draft and final paper).
107. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, Letter from Laura Fair to Roberts, April 2, 1953. Fair wrote comments on her copy of Roberts' draft.
108. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, Letter from Dr. George Reed to Roberts, March 10, 1953. He discovered this upon his return to Quebec and speaking to someone in the provincial nurses' association.
109. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter from E. Kemp to Roberts, Aug. 18, 1953.
110. NAC, RG29, Vol. 317, File 435-6-4, Subcommittee on Training, Memorandum to the Subcommittee on Training of the Advisory Committee on Mental Health, from Edith Kemp, Feb. 22, 1953. In her report Kemp noted the provincial legislation in BC and Saskatchewan but she did not recommend adoption of the psychiatric nurse program for other Canadian provinces.
111. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to P. Stiver from Dr. Roberts, Aug. 12, 1953.
112. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to Dr. Roberts from P. Stiver, Aug. 26, 1953.
113. CNA Archives, Minutes of Educational Policy Committee, 1953, June 12-13. Minutes noted the work was not completed. One problem was the numerous committees involved in the project and the distance between committee members.
114. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Letter to Roberts from Pearl Stiver, Jan. 12, 1953. At the outset Stiver suggested the two groups should avoid duplication of work.
115. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Minutes of Advisory Committee on

Mental Health, Sept. 24, 1953. For McKerracher, service was the main function of students and he was always open about his belief.
116. Ibid. McKerracher was attempting to buy some time.
117. Ibid; NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Letter to the Honourable Treasury Board, Submission #312, Health, from Paul Martin, Oct. 17, 1949.
118. Ibid.
119. Ibid.
120. Ibid.
121. Ibid. Roberts' separate report conflicted with Kemp's report and together they created confusion for the rest of the committee.
122. NAC, RG29, Vol. 317, File 436-5-5, Subcommittee on Training, Letter from Pearl Stiver to Dr. G. Cameron, Deputy Minister of National Health, Sept. 17, 1953. Stiver noted that Roberts' copy was leaving Montreal on Sept. 17. It was not discussed at the advisory committee meeting on Sept. 24 because Roberts held it back once he read its contents.
123. CNA Archives, Minutes of Educational Policy Committee, June 12-13, 1953.
124. NAC, RG29, Vol. 1418, Black Binder, Subcommittee on Training, Canadian Nurses Association, Submission on Psychiatric Nursing to Chief, Mental Health Division, National Health and Welfare, Sept. 1953.
125. Ibid.
126. NAC, RG29, Vol. 305, File 435-3-7, Subcommittee on Training, Letter from McKerracher to Roberts, Sept. 29, 1953; Letter to McKerracher from Roberts, Oct. 6, 1953; Vol. 317, File 435-6-4, Pt. 3, Letter to Roberts from Gee, Oct. 23, 1953. Roberts had the interim report even prior to the Sept. 24 advisory meeting but he only shared it with these two doctors following that meeting.
127. Ibid. Roberts was going out of his way for these two doctors because of their provincial psychiatric nurses' legislation and their strong lobby. He recalled that he was of "tender age and experience" when he became the head of the mental health division so perhaps he was swayed by their pressure. See Roberts, 72.
128. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. G. Cameron from Dr. Roberts, Jan 8, 1954.
129. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Roberts to Gee, Oct. 26, 1953. By the "whole field", Roberts meant the whole country.
130. NAC, RG29, Vol. 305, File 435-3-7, Subcommittee on Training, Letter to McKerracher from Roberts, Oct. 6, 1953.
131. SAB, SRNA, R-993, 39A (3.2-2-2), Letter from K. Ellis to E. James, March 3, 1948. McKerracher did not support the Saskatchewan legislation and enlisted Ellis to fight Premier Douglas over this because he could not.
132. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Gee to Roberts, Oct. 23, 1953.
133. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Roberts from Gee, Nov. 23, 1953. Gee attached a copy of McKerracher's work so that Roberts could see it.
134. Ibid.
135. Ibid. When he wrote this letter to Roberts, Gee was attempting to discover the

report's writer.
136. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Roberts to Stiver, Oct. 27, 1953 and letter to Roberts from Stiver, Oct. 30, 1953.
137. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Roberts from Gee, Nov. 23, 1953.
138. It was noteworthy that Roberts did not suspect McKerracher of the leak since only Gee and McKerracher had a copy of the CNA's interim report. Perhaps the fact that Roberts and McKerracher were friends caused him to miss this clue. It was perhaps easier to blame Stiver.
139. CNA Archives, Minutes of Executive Committee, June 6, 1954. This letter to Roberts from W. Butcher, Secretary of the Canadian Council of Psychiatric Nurses, Nov. 26, 1953, was attached to these minutes. Butcher worked at Gee's hospital.
140. SAB, PH3, File 9A, Letter to Dr. A. Campbell from Dr. J. MacNeill, Dec. 30, 1937. MacNeill told Campbell he would not hire RNs "off the street" to care for mental patients. Also see SAB, SRNA, R-993, 43F (4.2-9), Letter to K. Ellis from McKerracher, June 18, 1947. McKerracher's resistance to RNs at his hospitals was related to his belief in service over education.
141. NAC, RG29, Vol. 1690, File 437-11-5, Pt.1, Subcommittee on Training, A Summary of Activities Concerning Psychiatric Nursing, 1960. Also see RPNAS Archives, North Battleford, Filing Cabinet, Minutes of the Subcommittee on Training, Dec. 7, 1953.
142. RPNAS Archives, North Battleford, Filing Cabinet, Report of the Subcommittee on Training, Sept. 24, 1953. Roberts did not change the date on his revised report.
143. RPNAS Archives, North Battleford, Filing Cabinet, Minutes of the Subcommittee on Training, Dec. 7, 1953.
144. Ibid.
145. Ibid. It was unfortunate that Roberts did not link committee members' names to these comments. The anonymity gave Roberts an opportunity to generalize and perhaps embellish some of these comments.
146. Ibid.
147. Ibid. Gee and Osmond had a lot riding on the outcome of this meeting. Montgomery and Reed did not. Roberts was advocating for the underdog.
148. AO, RG10-107-0-178, Container 25, Nurses, 18-7-3, Memo from Dr. R. Montgomery to Dr. J. Weber, Ontario Hospital, Woodstock re-psychiatric or registered nurses for Ontario Hospitals, Dec. 18, 1953. Montgomery sent same memo to all medical superintendents regarding their Oct. 2 superintendents' conference and Roberts' desire to institute psychiatric nurses across Canada. Montgomery stated he was not interested in Roberts' plan.
149. AO, RG10-107-0-178, Container 25, Nurses, 18-7-3, Memo from Dr. J. Weber to Dr. Montgomery re-psychiatric nurses, Dec. 16, 1953. Weber wanted to know who had assessed the Saskatchewan curriculum.
150. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, June 5-6, 1952; NAC, RG29, Vol. 317, File 435-6-4, Subcommittee on Training, Memorandum to the Subcommittee on Training of the Advisory Committee on Mental Health, from Edith Kemp, Feb. 22, 1953; NAC, RG29, Vol. 1418, Black binder, Subcommittee on Training, Canadian Nurses Association,

Submission on Psychiatric Nursing to Chief, Mental Health Division, National Health and Welfare, Sept. 1953.

151. SAB, R594, Box 22, Session 1948, 5th Session of 10th Legislature.

152. Roberts' predecessor Dr. Stogdill was aware that Cameron did not want the federal government imposing a training scheme on the provinces. See NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Advisory Committee Meeting Minutes, Jan 22-23, 1951. Stogdill had been "burned" once when he lost Ogilvie and he refused to let it happen again. In an effort to build his case Roberts however had been cautious and even deceitful about what information Dr. Cameron received around this topic. He lied to Cameron about the CNA interim report being circulated to the advisory committee and in the same memo reassured Cameron that Dorothy Percy and he had been discussion the training issue. He "used" her name to lend nursing credibility. See NAC, RG29, Vol. 317, File 435-6-4, Subcommittee on Training, Memo to Cameron from Roberts, Jan. 8, 1954.

153. Percy, 1470-71, 1479. Percy had just returned to Ottawa from a one year leave-of-absence on a fellowship from the World Health Organization. Also see Zilm, 188 and NAC, RG29, Vol. 904, File 437-4-14, Proceedings of the Federal-Provincial Meeting on Mental Health and Psychiatric Nursing, Ottawa, June 28-30, 1966. Percy claimed she knew little about psychiatric nursing.

154. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. C. Roberts from D. Percy, Dec. 29, 1953. The underlining is Percy's.

155. The Canadian Council of Psychiatric Nurses began with just a few psychiatric nurses in Saskatchewan and British Columbia in 1949. It changed its name to the Psychiatric Nurses Association of Canada in 1966 but did not incorporate until 1974. The association folded in 1999. See RPNAS, *Fifty Years in Review* (Saskatoon: Type Write Productions, 1998). Following its demise the executive directors of the four western psychiatric nurses' associations formed the Registered Psychiatric Nurses of Canada (Inc.) and refers to itself as a national body. However, registered psychiatric nurses themselves are not members of this body. Annette Osted, telephone interview by writer, Winnipeg, MB, July 10, 2002.

156. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. Roberts from Dorothy Percy, March 3, 1954.

157. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, Letter from Laura Fair to Roberts, April 2, 1953; RPNAS Archives, North Battleford, Filing Cabinet, Minutes of the Subcommittee on Training, Dec. 7, 1953. Roberts' minutes noted that "members agreed" so it can be assumed Montgomery agreed, at least outwardly. He took the proposed idea back to his medical superintendents. AO, RG10-107-0-178, Container 25, Nurses, 18-7-3, Memo from Dr. R. Montgomery to Dr. J. Weber, Ontario Hospital, Woodstock re-psychiatric or registered nurses for Ontario Hospitals, Dec. 18, 1953.

158. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Roberts from Gee, Feb. 8, 1954.

159. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Gee from Roberts, Feb. 17, 1954.

160. NAC, RG29, Vol. 1418, Black Binder, Subcommittee on Training, Canadian Nurses Association, Submission on Psychiatric Nursing to Chief, Mental Health

Division, National Health and Welfare, Sept. 1953.
161. CNA Archives, Minutes of Executive Committee, June 6, 1954. Minutes written by Roberts of the April 5 and 6 meeting were attached, along with minutes written by Frances McQuarrie of the same meeting.
162. Ibid.
163. Ibid.
164. Ibid.
165. CNA Archives, Minutes of Executive Committee, June 6, 1954.
166. CNA Archives, Minutes of Executive Committee, June 6, 1954. Minutes written by Roberts of the April 5 and 6 meeting were attached, along with minutes written by Frances McQuarrie of the same meeting.
167. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. C. Roberts from D. Percy, Dec. 29, 1953. There was nothing documented from Roberts in reply to Percy's concern–he did not clarify it for her. However they could have simply discussed the issue.
168. Percy's review of Roberts' subcommittee on training report in Dec. 1953 and her presence at this April 5-6, 1954 joint meeting were tactics used by Roberts to validate/justify to Dr. Cameron where he was going with the western psychiatric nurses. Percy was the requisite nurse.
169. NAC, RG29, Vol. 904, File 437-4-14, Proceedings of the Federal-Provincial Meeting on Mental Health and Psychiatric Nursing, Ottawa, June 28-30, 1966, 48. It would not have been appropriate for Percy to speak out against Roberts' plan.
170. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Dr. G.D. Cameron to Miss P. Stiver, April 26, 1954.
171. WGH Alumnae Archives, Journal Collection, Evelyn Mallory, "The Preparation of Nursing Personnel for the Care of the Mentally Ill", *The Canadian Nurse* (Nov. 1954): 869-878. It was notable that Marjorie Keyes of the CMHA transferred her work on psychiatric nursing education for the association to the CNA committees.
172. CNA Archives, WY160, C25, "The Preparation of Nursing Personnel for the Care of the Mentally Ill", the Committee on Educational Policy, June, 1954. The use of the term psychiatric nursing here was notable for at one planning meeting they discussed that nurses practised psychiatric nursing, not psychiatry. See Minutes of Educational Policy Committee, June 12-13, 1953. This was an attempt, in writing, to gain some control of the specialty from psychiatrists.
173. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, Letter to Roberts from Pearl Stiver, Jan. 12, 1953. Stiver suggested sharing resources "to avoid duplication" but that did not occur, especially by Roberts. He got their interim report but he did not share the Kemp report or his subcommittee report.
174. NAC, RG29, Vol. 313, File 435-5-56, Letter from Frances McQuarrie, CNA to Dr. Roberts, Feb. 8, 1954. Plans for the biennial meeting were shared with Roberts.
175. NAC, RG29, Vol. 313, File 435-5-56, Letter from Evelyn Mallory, Chairman, Committee on Educational Policy, CNA to Dr. Roberts, May 15, 1954. Mallory asked him to "set the stage" with contextual information.
176. CNA Archives, Annual Meeting Folios, 1912-54, Box 2, File 5, "Address to the Meeting of the CNA", Banff, June 10, 1954, C. Roberts, MD. Also see WGH Alumnae Archives, Journal Collection, Charles Roberts, "Nursing the Mentally Ill", *The Canadian*

Nurse (Nov. 1954): 878-883.
177. NAC, RG29, Vol. 318, File 435-6-4, Subcommittee on Training, Letter to Dr. Gee from Roberts, Sept. 14, 1954. Roberts advised Gee that the advisory committee meeting was deferred until March, 1955 and not to be concerned with the relationship of the subcommittee on training to the advisory committee.
178. UofS Archives, Examining Board for Psychiatric Nurses, Outline of the training program, D. McKerracher, 1948. Also see Joel Paris, "Canadian Psychiatry Across 5 Decades: From Clinical Inference to Evidence–Based Practise", *Canadian Journal of Psychiatry* (Feb 2000): 34-39. The psychodynamic framework for treating mental illness was not as popular in Canada as in the United States and was practised by only a handful of psychiatrists in Canada's largest cities. With new pharmacological discoveries, biological psychiatry was the framework of choice.
179. Dept. of National Health and Welfare, Research Div., "Mental Health Services in Canada, Memorandum #6" (Ottawa: Queen's Printer, 1954), 83-84.
180. Bregg initially graduated from the Ontario Hospital, New Toronto in 1940. In the mid-1940's she took the one-year teaching/administration post-graduate course at the University of Toronto. She taught psychiatric nursing at Northwestern University in Cleveland following her work at the Toronto Psychiatric Hospital. See Margaret Gorrie, "Nursing", in *TPH: History and Memories of the Toronto Psychiatric Hospital, 1925-1966* ed. E. Shorter (Toronto: Wall & Emerson, 1996), 193-217. Gorrie described Bregg as a nurse "ahead of her time". For details around Bregg and Peplau see Elizabeth Carter, "Hildegard Peplau: Our Professional Compass", *Journal of the American Psychiatric Nurses Association* (2000):70-71. Carter paid tribute to Peplau and described the relationship between Bregg and Peplau. Peplau was a pioneer and leader in American psychiatric nursing for fifty years. See Barbara Callaway, *Hildegard Peplau: Psychiatric Nurse of the Century* (New York: Springer Publishing, 2002).
181. WGH Alumnae Archives, Journal Collection, Elizabeth Bregg, "Providing Nursing Service for the Mentally Ill", *The Canadian Nurse* (Nov. 1954):883-887.
182. Church, 205-212.
183. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. C. Roberts from D. Percy, Dec. 29, 1953.
184. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Note to Roberts written on Banff Springs Hotel stationery from Dorothy Percy, Thursday. It was interesting that Roberts actually saved and filed this note. It showed that even nursing leaders were required to prop up doctors' power.
185. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Roberts from George Carty, June 17, 1954.
186. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter to Roberts from Gee, Aug. 17, 1954.
187. NAC, RG29, Vol. 317, File 435-6-4, Pt.4, Subcommittee on Training, Letter to Dr. Cameron from P. Stiver, July 20, 1954; Letter to Stiver from Cameron, Aug. 4, 1954. Their letters discussed the resolution and Cameron's request of April 26.
188. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Press Release for release June 9, 1954. Dr. Reva Gernstein, a psychologist on staff at the CMHA sent Roberts the draft copy of this press release. Since Roberts and Gernstein sat together on committees at the CMHA, there is some indication that Roberts arranged this

poll with Gernstein. More recent research suggests that the federal government's communication machinery has a reputation for being partisan and propagandist. See Ken Rubin, "A High Price for Hot Air", *Globe and Mail* (April 8 2002):A12.

189. Bregg, 883-87; Roberts, 878-883.

190. NAC, RG29, Vol. 313, File 435-5-56, Letter to Roberts from Stiver, June 29, 1954.

191. NAC, RG29, Vol. 317, File 435-6-4, Pt.4, Subcommittee on Training, Letter to Dr. Cameron from P. Stiver, July 20, 1954; Letter to Stiver from Cameron, Aug. 4, 1954. Their letters discussed the resolution and Cameron's request of April 26; CNA Archives, Minutes of Executive Committee, 1954, June 6, June 12. Bregg's name was astutely put forward by Alice Girard, Director of Nursing, University of Montreal Hospital.

192. NAC, RG29, Vol. 313, File 435-6-4, Pt.3, Subcommittee on Training, Letter to D. Percy from Frances McQuarrie, CNA, June 29, 1954. Percy and McQuarrie were directed by Roberts to spend the summer gathering and evaluating curricula for Bregg's new committee and for the subcommittee on training.

193. CNA Archives, WY160, C25, 1954, Report of the Committee on Psychiatric Nursing, Nov. 12, 1954. Members were Mallory, Pullan and Geneva Purcell (Royal Victoria, Montreal). Pullan lobbied CNA executive committee members to get onto this committee and was nominated by Helen McArthur. See CNA Archives, Minutes of Executive Committee, 1954, June 12. The report was very short. Also see NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 21, 1954. Roberts expanded on the committee report, noting some items which were not explicitly reported. A main concern was that psychiatrists had designed the curricula and nursing was invisible.

194. Ibid. The report was forwarded to the nursing education committee and then to the executive committee, CNA.

195. CNA Archives, WYICAICC, Edu, 1955, Minutes of the Nursing Education Committee Meeting, Jan 28-29, 1955. Edith Pullan spoke to Bregg's committee report and emphasized that action was needed to implement the June, 1954 recommendations. This was her first nursing education committee meeting and she told Mallory that she wished to keep psychiatric nursing on the committee's agenda. See letter from Pullan to Mallory, Jan 11, 1955. Pullan had never been happy with the two year Essondale curriculum and had been pushing for improvements since 1951. She was a key figure.

196. Ibid; Roberts, 878-883.

197. CNA Archives, Minutes of Educational Policy Committee, June 12-13, 1953.

198. The interim report was held back from their Sept. 1953 meeting and there was no meeting in 1954. The provincial directors had no idea that there was a CNA recommendation for a standardized auxiliary course.

199. CNA Archives, WYICAICC, Edu, 1955, Minutes of the Nursing Education Committee Meeting, Jan 28-29, 1955; Minutes of Executive Committee, Feb. 17, 1955. The members of the executive committee adopted the nursing education committee's report, including Bregg's report. It is not known if Cameron was sent their June paper.

200. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 21, 1954.

201. Ibid; RG29, Vol. 313, File 435-6-4, Pt.3, Subcommittee on Training, Letter to D. Percy from Frances McQuarrie, CNA, June 29, 1954. It is not known what they

discussed or what, if any input Percy had to the Bregg committee decisions. She represented the federal government in the curricula assessment project with the CNA. Roberts had used Percy as a source of nursing credibility and now that decision was playing havoc with his goal.

202. Ibid. Roberts also suggested Gee needed to talk with Edith Pullan, Gee's own superintendent of nurses, because Roberts was aware she had served on Bregg's committee and was "outspoken" on the topic. Evelyn Mallory was a WGH graduate and obtained her undergraduate and graduate degrees at Teachers College, Columbia University. She was director of nursing at WGH and MARN president prior to joining UBC in 1943. See Zilm and Warbinek, 100-158.

203. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Roberts from Gee, Jan 4, 1955. It is not known why Gee did not talk with Pullan, for she also sat on Bregg's committee. Perhaps he did not like the fact that she had gone public with her concern about tensions between RNs and psychiatric nurses in western Canada. They also differed in their ideas about the training course offered at the Essondale Mental Hospital.

204. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Jan 10, 1955. Roberts believed that there was something underhanded going on and he said he could not write about it. Perhaps he suspected an information leak in his office or at Gee's end, or that Percy had conspired with CNA's McQuarrie. These educated nurses were a threat to the psychiatric monopoly on education.

205. Ibid.

206. CNA policies on nursing education noted the "basic preparation for the professional nurse should be general rather than specialized". See CNA Archives, Minutes of Executive Committee, Oct. 22, 1953.

207. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. C. Roberts from D. Percy, Dec. 29, 1953.

208. CNA Archives, Minutes of Executive Committee, Feb 17, 1955.

209. CNA Archives, WM2, A48I, Advisory Committee on Mental Health, Subcommittee on Training, "Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill", May, 1955. Edith Kemp represented the AARN, Lola Wilson the SRNA and Alice Wright, RNABC. Mallory wrote the final draft with input from her education committee. There was no input from the three psychiatric nurses' associations.

210. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, "Some Comments and Opinions Regarding Psychiatric Training Expressed by Provincial Nurses' Associations", March, 1952. The MARN board favoured a licensed practical nursing course added to the mental hospital program.

211. CNA Archives, WM2, A48I, Advisory Committee on Mental Health, Subcommittee on Training, "Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill", May, 1955. Alberta's Ponoka Mental Hospital was used as an example of where both programs were offered, but separately.

212. CNA Archives, WM2, A48I, Advisory Committee on Mental Health, Subcommittee on Training, "Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill", May, 1955. The education committee designed the curricular outline for the possibility that some western mental hospitals would still need to graduate psychiatric nurses along with registered nurses. However

such graduates would be able to complete the general nursing component at a later date.
213. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Dr. G.D. Cameron to P. Stiver, April 26, 1954.
214. CNA Archives, WM2, A48I, Advisory Committee on Mental Health, Subcommittee on Training, "Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill", May, 1955. The focus of this report was to increase the number of registered nurses in the three provinces' mental hospitals.
215. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947. Ogilvie suggested all combined courses needed to be three years in length as in Ontario.
216. CNA Archives, Minutes of Executive Committee, June 6, 1954. Minutes written by Roberts of the April 5 and 6 meeting were attached, along with minutes written by Frances McQuarrie of the same meeting.
217. NAC, RG29, Vol. 1418, Subcommittee on Training, Minutes, July 7-8, 1955. Also see Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 20, 1955.
218. Ibid. Also see Vol. 318, File 435-6-4, Pt.4, Letter to Dr. Roberts from Edward Jones, President of the Alberta Psychiatric Nurses Association, Aug. 3, 1955.
219. CNA Archives, Minutes of Executive Committee, June 6, 1954. This letter to Roberts from W. Butcher, Secretary of the Canadian Council of Psychiatric Nurses, Nov. 26, 1953, was attached to these minutes. Butcher worked at Gee's hospital.
220. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Subcommittee on Training, Letter to Dr. Roberts from Bob Montgomery, June 15, 1955. Montgomery was not on the joint committee but still on the subcommittee on training, hence his input.
221. RPNAS Archives, North Battleford, Letter from Vowles to Butcher Oct. 24, 1955. McKerracher's influence was evident here for it reflected what he previously wrote for the nurses in order to incite them. See NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Letter to Roberts from Gee, Nov. 23, 1953. McKerracher believed the combined course was a dismal experiment because it emphasized education more than service. Dr. Osmond, medical superintendent at Weyburn attended the joint meeting but did not speak out against the plan and there was no psychiatric nurse representative from this province.
222. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Minutes of Advisory Committee on Mental Health, Sept. 24, 1953.
223. RPNAS Archives, North Battleford, Letter from Vowles to Butcher Oct. 24, 1955.
224. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, June 5-6, 1952.
225. First its interim report was not shared. See NAC, RG29, Vol. 305, File 435-3-7, Letter to McKerracher from Roberts, Oct. 6, 1953. Then Roberts received a copy of the completed report in May, 1954 but it was thought he did not share it with Cameron. See CNA Archives, WYICAICC, Edu, 1955, Minutes of the Nursing Education Committee Meeting, Jan. 28-29, 1955. There was no advisory committee meeting held in 1954 and Roberts told Gee that he need not be concerned with the relationship of the subcommittee on training to the advisory committee. See NAC, RG29, Vol. 318, File 435-6-4, Letter to Dr. Gee from Roberts, Sept. 14, 1954. It is not known why Roberts cancelled the advisory committee meeting in 1954. Roberts' report of the subcommittee on training to the 1955 advisory committee meeting still did not mention the CNA's final report. See

Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health, Minutes, Feb 28, 1955.
226. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health, Minutes, Nov. 19-20, 1956.
227 Ibid. Also see minutes, Feb. 28, 1955. At the 1955 meeting Roberts was still waiting for a formal report from Mallory. Thus the proposed combined program put forward by her committee created another change in focus.
228. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health, Minutes, Feb. 28, 1955. Bott was affiliated with a medical school.
229. Ibid. It is not known if Bott ever got his report.
230. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health Minutes, June, 1957.
231. Roberts, 87.
232. Ibid., 88-89. Also see Simmons, 90. Simmons noted that as the provinces began taking over mental health policy, the mental health division and the advisory committee's influence decreased.
233. Roberts, 79-80. Roberts viewed the western group as the underdogs. His viewpoint was similar to that held by Dr. Shumiatcher when Saskatchewan's psychiatric nurses needed his help. See SAB, R-33.5, 109 (13-5-2), Letter to Gardiner from M. Shumiatcher, April 14, 1947.
234. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health, Minutes, Nov. 19-20, 1956. Mallory's Oct. 1956 progress report was attached to the minutes. This committee became known as "special committee to explore curriculum".
235. Ibid. It might have been that twenty committee members was slowing the work.
236. Ibid; Vol. 1690, File 437-11-5, Pt.1, Subcommittee on Training, A Summary of Psychiatric Nursing, 1960. Dr. Gee presented the committee's work to the Canadian Council of Psychiatric Nurses at their June, 1957 meeting in Vancouver. All parties were encouraged by the progress and wanted the work to continue.
237. NAC, RG29, Vol. 1690, File 437-11-5, Pt.1, Subcommittee on Training, A Summary of Psychiatric Nursing, 1960. Horwood took a position with the WHO and she had been the committee's psychiatric nursing "expert", originally from Ontario. Gee resigned because of his medical workload and Edith Pullan left her position at Essondale in 1957 to become director of nursing at the Royal Columbian Hospital in Vancouver. Pullan had been consistently involved in the issue since 1951 and was a key player. Anna Tremare, telephone interview with writer, Winnipeg-Vancouver, April 19, 2002.
238. Ibid. Mallory was known to have been committed to improving psychiatric nursing education both for general nursing students and the western provinces' psychiatric nurses. See Zilm and Warbinek, 134.
239. Percy, 1479.
240. Ibid.
241. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Subcommittee on Training, Letter to Dr. Roberts from Bob Montgomery, June 15, 1955.
242. Simmons, 87-90.
243. CNA Archives, Minutes of Executive Committee, 1957, Feb. 14-16.
244. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training,

Comments from the Provinces, Feb. 1953. See RNAO comments to Gertrude Hall's survey for the mental health division.
245. AO, Gov. Doc., HE, Miscell. Box 2, File 14, 1955, Brochure "Opportunities in Psychiatric Nursing in Ontario", Minister of Health, Hon. M. Phillips.
246. AO, RG10-20-A-1-1.4, Container 1, Minutes of Superintendents' Conferences, April 17, 1953. The Ontario government had been promising the mental hospitals this course for about five years.
247. AO, RG10-107-0-704, Nurses, N-1, Letter to Mr. D. Hicks, Department of External Affairs, Ottawa, from Laura Fair, Sept. 8, 1955.
248. AO, RG10-20-A-1-1.4, Container 1, Minutes of Superintendents' Conferences, May 2, 1952. Laura Fair advised that the plan had been deferred until 1954. It took until 1970 before all Ontario students received the psychiatric experience. See Dorothy Sillars, "The Development of Community Mental Health Nursing in Ontario, 1917-1947" (Masters' thesis, University of Toronto, 1983), 50-55. From 1965 onward about 95% of Ontario students received the affiliation. The exceptions were schools where distances to psychiatric facilities made an affiliation difficult. In 1970 all provincial nurses' associations utilized the CNA's registration examination which included a separate psychiatric nursing component. Mandated 8 week affiliations in Ontario were an outcome of the national exam. Letter from Judith Oulton, Executive Director, CNA, to writer, March 14, 1994.
249. AO, RG10-107-0-710, Container 110, Affiliate Course for Nurses, N-3-1, Memo from Dorothy Dick, Director, Nursing to Directors of Nursing, Ontario General Hospitals' Schools re-psychiatric affiliations, Aug. 12, 1955.
250. WGH Alumnae Archives, Journal Collection, Muriel Doucett, "Our Concepts of a Psychiatric Nursing Affiliation", *The Canadian Nurse* (Oct. 1953):791-793.
251. CNO Archives, Nursing Education, Annual Report on Schools of Nursing in Ontario, Feb., 1955. For a discussion on the rapid growth of the psychiatric unit system in Ontario see Simmons, 65-83.
252. CNO Archives, Nursing Education, Schools of Nursing, Information Files. A page per school cited dates opened and closed. ND. Also see Cheryl Forchuk and Donna Tweedell, "Celebrating our Past, The History of Hamilton Psychiatric Hospital", *Journal of Psychosocial Nursing* (Oct. 2001):16-24. When the school closed in 1953, 240 nurses had graduated. The Alumnae Association remains active.
253. AO, Gov. Doc., HE, Miscell. Box 2, File 24, 1955, Brochure "Opportunities in Psychiatric Nursing in Ontario", Minister of Health, Hon. M. Phillips.
254. AO, RG10-107-0, File 163, Container 22, Nurses Affiliate Courses, Letter to Laura Fair from Miss Bird, Hospital for Sick Children, Nov. 6, 1952. The students affiliating from Ontario Hospital, Whitby wrote to *The Toronto Star* which published their letter. Bird was not empathetic and advised Fair that she would instruct the girls on the history of nursing education.
255. AO, RG10-107-0-704, Nurses, N-1, Memo from Dick to Phair re-schools of nursing, Dec. 1, 1955. Her memo reminded Phair that 1951 legislation put the RNAO in charge of registration. There were some similarities between Dicks' suggestions and the new Metropolitan School of Nursing CNA project in Windsor.
256. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept. 30, 1947, Report from the Special Committee on Psychiatric Nursing, July

10, Sept. 5, 1947.
257. AO, RG10-107-0-704, Nurses, N-1, Memo from Dr. Phair, Deputy Minister to Miss Dick, Director, Nursing, re-reorganization of schools of nursing, Dec. 30, 1955. The file held no further documentation on the outcome of Phair's discussion.
258. Vivian Wood, "Nursing Education: The Move from Hospital Schools of Nursing–an Historical Perspective", *International Journal of Nursing Studies 21, 3* (1984): 183-192. Kingston and Brockville closed in 1971 and Whitby in 1972. Ontario's community colleges were known as colleges of applied arts and technology (CATT).
259. AO, RG10-107-0-704, Nurses, N-1, Memo from Dr. Buck, Chief, Mental Health to Superintendents re–Registered Nurses, Oct. 29, 1956.
260. McKee, BMHC, SB49C, Annual Reports, Brandon Hospital for Mental Diseases, 1952; SB48, Yearbooks, "The Ego", 1952.
261. Ibid.
262. NAC, RG29, Vol. 317, File 435-6-4, Pt. 2, Subcommittee on Training, Comments from the Provinces, Feb, 1953.
263. PAM, H-16-19-1A, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Brandon, Letter to Ivan Schultz from Stuart Schultz, May 14, 1951. The Brandon students were affiliating and there were also less mental nurse diploma students to cover the wards.
264. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, 1950-57, Psychiatry, Meetings, Meeting with medical superintendents, Dr. Pincock and Hon. Bell, Oct. 28, 1953. There had been a post-war attempt between the Selkirk and Portage institutions to offer a more consistent training vis-à-vis a 4 month lpn course but Brandon never participated. See Box 19, Temp. Box 34, Health and Welfare Minister's Office Files, Psychiatry, Memo to Jackson's own file re-meeting, March 2, 1946.
265. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health Div., Mental Health Advisory Committee Meeting Minutes, Jan. 22, 1951 and June 5, 1952. Pincock was rarely cited in the minutes and he was not part of the McKerracher-Gee lobby for the western psychiatric nurse program.
266. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, 1950-57, Psychiatry, Meetings, Meeting with medical superintendents, Dr. Pincock and Hon. Bell, Oct. 28, 1953. Schultz had seen a huge drop in the two year diploma program and knew he would not get students to enroll. Neither Schultz or Pincock wanted to minimize the general nursing needs of their patients. Also see MARN Archives, 47-24-058, Board Meeting Minutes, May 31, 1954.
267. McKee, BMHC, SB17, File: Graduation Programs.
268. McKee, BMHC, SB6, File 1, Education, Copy of advertisement for nursing education, June, 1955. The male attendants had about 200 less classroom hours than females at Brandon. They were not called psychiatric nurses.
269. MARN Archives, 47-24-058, Board Meeting Minutes, Jan. 14, 1953. Legal counsel for the MARN was present and discussed this request sent from the health ministry. The schools which offered the affiliation were Winnipeg General, St. Boniface, Brandon General, Grace and Childrens. Only the Winnipeg General required all students to have an 8 week experience. See NAC, RG29, Vol. 317, 435-6-4, Pt.1, Letter to G. Hall, CNA from Lillian Pettigrew, MARN re-psychiatric training, Jan. 22, 1952. About

300 students received the affiliation annually.
270. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, Psychiatry, Letter from Pincock to Dr. Jackson, Deputy Minister, July 2, 1948. Pincock had been in Ottawa at a subcommittee on training meeting where Elsie Ogilvie promoted affiliations. It was another 7 years before psychiatric nurses organized.
271. MARN Archives, 47-24-058, Board Meeting Minutes, Jan. 14, 1953.
272. Ibid. Also see Board Meeting Minutes, March 21, 1952. The membership discussed the letter sent from CNA with its endorsement of the CMHA's request for provincial associations to encourage affiliations. The MARN Board was unduly optimistic about the affiliation for it did not become mandatory in Manitoba until sometime between 1967 and 1970. There was no evidence to support a date prior to 1970 and the adoption of the national CNA exam. Letter from Judith Oulton, Executive Director, CNA, to writer, March 14, 1994.
273. PAM, H-16-19-1, Off-Site, Box 3, Temp. Box 18, Health and Welfare Minister's Office Files, 1950-57, Psychiatry, Meetings, Meeting with medical superintendents, Dr. Pincock and Hon. Bell, Oct. 28, 1953.
274. McKee, BMHC, SB6, File 1, Education, Minutes of Nursing Education Committee, MARN, July 14, 1955; AO, RG10-107-0-710, Container 110, Affiliate Course for Nurses, N-3-1, Memo from Dorothy Dick, Director, Nursing to Directors of Nursing, Ontario General Hospitals' Schools re-psychiatric affiliations, Aug. 12, 1955.
275. MARN Archives, Beatrice Fines, *History of the Manitoba Association of Registered Nurses* (Winnipeg: MARN, 1978), 163-64. Fines described the 1957 meeting. Also see CNA Archives, Minutes of Executive Committee, 1957, Feb. 14-16. All associations were asked to meet with their governments.
276. NAC, RG29, Vol. 318, 435-6-4, Pt.5, Letter to Roberts from Stiver with attached brief from the CNA to the "Royal Commission on the Economic Future of Canada", March 9, 1956.
277. SAB, SRNA, R-993-39F (3.2-8-2), Letter from Marion Jameson, Weyburn to Miss Wilson, Dec. 14, 1950.
278. SAB, SRNA, R-993-39F (3.2-8-2), Letter to Ellis from Wilson, Jan. 2, 1951; Letter from E. Leslie, Barrister to L. Wilson, Feb. 2, 1951; Letter from Dr. F. Mott to L. Wilson, March 2, 1951. Wilson was from Ontario and had no prior knowledge about Saskatchewan's psychiatric nurses. She was a graduate from the University of Toronto's school of nursing and had an administration certificate from the University of Alberta. See Marguerite Robinson, *The First Fifty Years* (Regina: SRNA, 1967), 142-146.
279. SAB, SRNA, R-993-39F (3.2-8-2), Letter to Dr. F. Mott from L. Wilson with attached memorandum titled "Psychiatric Nurses", Jan. 25, 1951.
280. SAB, R-349, Kahan Papers, William Vowles memoirs "For the Archives", 1964.
281. Ibid. Not all psychiatric nurses were registering and Vowles believed this designation would provide some incentive.
282. Ibid.
283. NAC, RG29, Vol. 317, 435-6-4, Pt.1, Subcommittee on Training, Letter to G. Hall, CNA, from Alice Wright, RNABC, Oct. 26, 1951. Wright explained the "psychiatric nurses" were given the title "licensed" by order-in-council.

284. RPNAS Archives, North Battleford, North Battleford Psychiatric Hospital Yearbook, 1957; Bill Vowles, "The Question has been Asked", 1960. It was not clear re-what association this pledge came from. It also became the Canadian Council of Psychiatric Nurses' pledge.
285. RPNAS Archives, North Battleford, Letter from Dr. S. Lawson, Superintendent to Mr. Vowles, May 2, 1950. Lawson discussed the agreement and attached exam results.
286. J.D. Ward, "Some Observations of the Psychiatric Nursing Program", *Saskatchewan Psychiatric Services Journal 1,3* (1953):30-34.
287. Ibid., 34.
288. SAB, R11-14-19, Letter from T.J. Bentley to Rev. McGookin, April 30, 1951. A public visiting committee assessed the issue and complained to the minister.
289. RPNAS, Archives, North Battleford, Bill Vowles, "The Question has been Asked", 1960. Vowles recalled McKerracher attending their psychiatric nurses' meeting in Oct. 1953 and handing over his "Report on RN Study Made to Subcommittee on Training". Also see letter from Vowles to Butcher, Oct. 24, 1955.
290. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 21, 1954.
291. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Letter from Dr. G.D. Cameron to Miss P. Stiver, April 26, 1954. Also see Roberts, 878-883.
292. Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 153. McKerracher continued to attend the federal government's mental health advisory meetings as an academic. He did not comment on Mallory's project at UBC. See NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Advisory Committee on Mental Health, Minutes, Nov. 19-20, 1956; SAB, R-11-14-19, Letter to Bentley from McKerracher, Dec. 2, 1955. McKerrracher lobbied for a new psychiatric ward at the University Hospital in Saskatoon and became its chief of psychiatry.
293. McKerracher advised them to do this when he realized his dream for national acceptance was not going to be realized. See RPNAS Archives, North Battleford, "Report on RN Study Made to Subcommittee on Training", Oct. 1953. It was either focus inward, or accept a shorter national auxiliary course. It has been said that McKerracher promoted his training program without regard for those students who were in a "dead end" career. Letter from Dr. Helen Mussallem to writer, June 8, 1995. Mussallem knew McKerracher in the 1950's and 1960's.
294. RPNAS Archives, North Battleford, Letter from Bill Vowles to Mr. H. Krueger, Secretary, SPNA, April 2, 1967. Vowles believed that it was a waste for taxpayers if the nurses left the province.
295. SAB, SRNA, R-993-39F (3.2-8-2), Letter from L. Wilson to Dr. F. Mott with memorandum, Jan. 25, 1951.
296. SAB, SRNA, R-326, 111 (6-1-2-0 to 1), Health Survey Committee, *Saskatchewan Health Survey Report: Health Programs and Personnel*, 1951. In contrast 300 Manitoba students got the affiliation.
297. SAB, SRNA, R-1271-94, Educational Policy Committee, Meeting Minutes, April 14, 1951.
298. SAB, SRNA, R-993, 43F (4.2-9), Letter from Lola Wilson to Dr. McKerracher, April 25, 1951.

299. SAB, SRNA, R-993, 43F (4.2-9), Letter from Mott to Wilson, July 10, 1951. Wilson and Mott discussed it in earlier meetings. Neither Mott or Wilson was aware that the Munroe Institute was not even accredited by the APA in 1951 and that McKerracher was using that to get his four extra weeks.
300. SAB, SRNA, R-993, 43F (4.2-9), Letter from E. Russell, School of Nursing, University of Toronto to Wilson, March16, 1951. Also see letter from Gladys Sharpe, Toronto Western, March 19, 1951.
301. SAB, SRNA, R-993, 43F (4.2-9), Letter from Nettie Fidler, Metropolitan School, Windsor, to Lola Wilson, March 17, 1951.
302. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dr. Mott from Wilson, June 13, 1951. It was clear that 12 weeks was acceptable, but not when they were limited to one small unit.
303. SAB, R-999, IX, 1. (172) 1A, Letter from Mott to McKerracher, June 13, 1951; SRNA, R-993, 43F (4.2-9), Letter from Mott to Wilson, July 10, 1951.
304. Ibid. Mott told McKerracher that there was considerable "bad feelings" expressed. Also see SRNA, R-993, 43F (4.2-9), Special Meeting on Affiliations with directors of nursing, May 24, 1951. Mott was perceived as more reasonable than McKerracher about their predicament.
305. SAB, SRNA, R-993, 43F (4.2-9), Letter from Wilson to Directors of Nursing in Schools, July 12, 1951 and June 1, 1951.
306. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dr. Mott from Wilson, June 13, 1951. Wilson said the only thing preventing mandatory affiliations was having only one facility available.
307. SAB, SRNA, R-1271-55, Council Minutes, Jan. 10, 1953.
308. SAB, SRNA, R-993, 43F (4.2-9), Letter from Wilson to Miss Gagne, Munroe Institute, March 1, 1954. Gagne was the head nurse under McKerracher.
309. APA, Nursing, Site Visits, Box 11, File 213, Munroe Wing, Regina General Hospital, Report of Nursing School, May, 1954.
310. SAB, R-999, IX 1. (172), E, Letter from McKerracher to Dr. F. Roth, Deputy Minister, March 8, 1954. This letter was full of lies and was an attempt to cover up his problem.
311. APA, Nursing, Box 16, File 371, Letters from McKerracher to Elsie Ogilvie, March 9, 1954 and March 29, 1954.
312. For example Ogilvie wrote a critical report about McKerracher's training program, and he in turn spoke out against her recommendations for psychiatric affiliations for general students. She continued to refer to his graduates as attendants. See WGH Alumnae Archives, Journal Collection, Anonymous, "Is This the Answer?", *The Canadian Nurse* (Sept. 1949):668-69. Ogilvie was on the CNA's public relations committee and this report cited the committee; NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Minutes, Oct. 1-3, 1947; APA, Nursing, Site Visits, Box 11, File 213, Munroe Wing, Regina General Hospital, Report of Nursing School, May, 1954. They disagreed from 1947 to 1949 when she left the federal government and five years later he said he hoped she was enjoying Washington, DC.
313. Ogilvie, 907-09.
314. APA, Nursing, Box 16, File 371, Letters from McKerracher to Elsie Ogilvie, March 9, 1954 and March 29, 1954.

315. SAB, SRNA, R-1271-55, Council Minutes, Jan. 10, 1953. They did not like the fact that their students received no lectures for the final six weeks and that the extra 4 weeks were solid service.
316. APA, Nursing, Box 16, File 371, Letter to McKerracher from Ogilvie, March 17, 1954. Letters from McKerracher March 9 and March 29, 1954. McKerracher painted a picture of school directors hostile to psychiatric nursing education which was not the case.
317. SAB, SRNA, R1271-94, Educational Policy Committee, Minutes, May 12, 1954. Also see APA, Nursing, Box 16, File 371, Letters from McKerracher to Ogilvie, March 9 and March 29, 1954. She must have been convinced of their hostility, for she told them on May 12 that "nursing had fallen down" in psychiatric nursing. It did not seem to be anything more than a missionary-like zeal for psychiatric nursing education, for instance, an exercise in power. Also see Olga Church, "That Noble Reform", 274. Church wondered how APA nursing consultants maintained their professional loyalties, given the unavoidable conflicts of interest between psychiatry and nursing. Church recommended further research on this topic.
318. APA, Nursing, Box 16, File 371, Letter to McKerracher from Ogilvie, March 17, 1954. McKerracher had lied to two deputy health ministers and Wilson since 1951 about the APA requirement and many assumptions had been made. Also see Church, 190-225 for a discussion on American nursing and the APA accreditation service. That service ended in 1955.
319. NAC, RG29, Vol. 318, 435-6-4, Pt.5, Letter to Roberts from Stiver with attached brief from the CNA to the "Royal Commission on the Economic Future of Canada", March 9, 1956. Saskatchewan was noted to have just 19 registered nurses who worked in psychiatric settings.
320. APA, Nursing, Box 16, File 371, Letter from McKerracher to Ogilvie, May 20, 1954. He signed this letter "sincerely yours" whereas prior letters were just "sincerely" as though he was indebted to Ogilvie for rescuing him.
321. SAB, SRNA, R1271-94, Educational Policy Committee, Minutes, May 12, 1954; R-1271-55, Council Minutes, Jan. 20, 1951.
322. SAB, SRNA, R-993, 43F (4.2-9), Letter to Ellis from Miss Jacques, Dec. 5, 1938. The affiliation remained optional in Saskatchewan and only at Munroe and then University Hospital until the early 1960's. By 1965 all schools offered the still-optional experience. Some students from the Regina Grey Nuns Hospital were the first to affiliate at the Weyburn Psychiatric Hospital in the early 1960's but even then there was resistance on the part of some psychiatric nurses who saw them as a threat to their positions. See RPNAS Archives, Weyburn, Filing Cabinet, Letter from Mr. M. Fladager to Association re–General Hospital Affiliates, ND. The writer had news of the pending affiliation and was upset that general students were to take on psychiatric nursing roles.
323. It was not until Percy reviewed the psychiatric nursing curricula from BC, Alberta and Saskatchewan and along with Frances McQuarrie of the CNA, compared these to general nursing curricula, that she had enough information to make an informed decision. That information gave her some authority with Roberts. That she met with Roberts to advise him of their findings was evidence of more confidence and authority. See NAC, RG29, Vol. 318, 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 21, 1954.
324. NAC, RG29, Vol. 336, File 436-5-5, Pt.2, Mental Health Nursing, Memo to

Roberts from Percy, Sept. 22, 1955.
325. AARN Archives, Dorothy Percy, "Mental Illness, A National Problem: Mental Health A National Challenge", *Alberta Association of Registered Nurses Newsletter*, (1957): 61-69. Percy delivered this paper on May 24, 1957 at the AARN annual meeting. She noted the American conferences she had attended.
326. AHCPMH, CMHA, National Office Records: Committee on Psychiatric Mental Health Services, Subcommittee of the Scientific Planning Council (Tyhurst Committee), Working Papers, "Working Paper on Nurses, Aides and Attendants", Dr. S. Lawson, 1957. McKerracher was no longer in the picture in Saskatchewan but his ideas about the service-driven medically controlled model of psychiatric nursing education lived on, as did the traditional disdain for registered nurses.
327. CNA Archives, WY160, C35, 1958, Report of the First Canadian Conference on Psychiatric Nursing in General Hospitals, McGill University/Allan Memorial Institute, Nov, 1958. Also see NAC, RG29, Vol. 1418, Subcommittee on Training, Minutes, July 7-8, 1955. Percy attended this meeting where the decision was made to go with the combined curriculum.
328. AHCPMH, CMHA, National Office Records: Committee on Psychiatric Mental Health Services, Subcommittee of the Scientific Planning Council (Tyhurst Committee), Working Papers, "Working Paper on Nurses, Aides and Attendants", Dorothy Percy, 1957.
329. The Tyhurst Committee worked on its document for about five years. There was no evidence of these two working papers in the final document. See AHCPMH, CMHA, National Office Records: Tyhurst.
330. In Ontario for instance Laura Fair, Edith Dick and superintendents of nurses at the Ontario Hospitals asked the RNAO executive to request the CNA's executive committee to lobby the federal government's mental health division for a psychiatric nursing consultant. See AO, RG 10-107-0-710, Container 110, Ontario Hospital Nurses, Memo to Miss Dick, Director, Nursing from Dr. Phair, Deputy Minister of Health, June 1, 1956; CNA Archives, Minutes of Executive committee, 1957, Feb. 14-16. The CNA executive committee supported the request but it was not acted upon by the federal government until 1964. Also see Percy, 1479-1481. For introspective comments see Percy, 61-69.
331. Within five years both models of education for psychiatric nursing were found, but only in the four western provinces. That this was to be a uniquely Western Canadian phenomenon became evident to Dr. Helen Mussallem in the early 1960's when she undertook a study of nursing education in Canada for the Royal Commission on Health Services. She interviewed senior federal health department officials and psychiatric hospital administrators and was told that "legal recognition for the distinct group of psychiatric nurses would stop at the Manitoba/Ontario border". Letter from Dr. Helen Mussallem to writer, June 8, 1995.
332. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health, Dominion-provincial conference on mental health, Minutes, Oct. 1-3, 1947. The dominion-provincial meeting attendees were the advisory committee members; Vol. 318, File 435-6-4, Pt.4, Letter to Gee from Roberts, Dec. 21, 1954 and letter to Roberts from Gee, Jan. 4, 1955.
333. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health, Mental Health

Advisory Committee Meeting, Minutes, June 5-6, 1952.
334. NAC, RG29, Vol. 314, File 435-6-1, Pt.1, Mental Health Div., Press Release, Mental Health Conference, Oct. 5, 1946.
335. Simmons, 66-7, 87-90.
336. Cyril Greenland, Jack Griffin, Brian Hoffman, "Psychiatry in Canada from 1951 to 2001", in *Psychiatry in Canada: 50 Years* ed. Q. Rae-Grant (Ottawa: CPA, 2001), 1-16. The authors described the mental hospital relationships.
337. Roberts, 226-227. Besides nurses, Roberts blamed administrators.
338. NAC, RG29, Vol. 317, File 435-6-4, Pt.2, Subcommittee on Training, Letter to Dr. Roberts from P. Stiver, Aug. 26, 1953. In her letter Stiver pointed out the CNA's 1936 curriculum, written almost 20 years earlier.
339. NAC, RG29, Vol. 1689, File 437-11-3, Pt.1, Mental Health, Mental Health Advisory Committee Meeting, Minutes, June 5-6, 1952. Roberts told committee members that the CMHA was responsible for educating general students in psychiatric nursing. Specifically it became Marjorie Keyes' mandate. While she was an RN, most were psychiatrists.
340. Edith Pullan initiated the process and stayed with the issue until she resigned from her position at the Essondale Psychiatric Hospital in 1957 and moved into general hospital nursing administration. She was committed to improving the education for licensed psychiatric nurses in BC vis-à-vis a combined curriculum. It is not known why she resigned, for she had worked in psychiatric nursing education and administration for almost 20 years. Perhaps she became frustrated with the slow progress of the new curriculum committee. Anna Tremare, phone interview by writer, Winnipeg-Vancouver, April 19, 2002.
341. The "battle at Banff" was a phrase given to the 1954 biennial meeting by the writer to describe the difference between Roberts' and Breggs' presentations. It was a battle of words only. See WGH Alumnae Archives, Journal Collection, Charles Roberts, "Nursing the Mentally Ill", *The Canadian Nurse* (Nov 1954):878-883; Elizabeth Bregg, "Providing Nursing Service for the Mentally Ill", *The Canadian Nurse* (Nov 1954):883-887. It meant that the struggles for control at the provincial level had escalated and there was much at stake.
342. Kathryn McPherson, *Bedside Matters. The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), 240-245.
343. The main players were Frances McQuarrie, Elizabeth Bregg, Evelyn Mallory, Edith Pullan and Dorothy Percy. Percy only became involved when she was asked by Roberts to evaluate western psychiatric nursing curricula. These nurses were from both central and western Canada, so it was not simply a case of putting up a fence by Ontario nurses at the province's western border. If Percy had not been involved in the curricular review there might have been suspicions about the motives of the nurses. She had no reasons except educational, to stop the eastward movement of the western training model, and in fact had been in favour of the plan until she saw the curricula.
344. Pinpointing the exact time that the move eastward died was a challenge inspired by an analysis of the exact day Canadian politics died. See Lawrence Martin, "I Can Tell You Exactly When Canadian Politics Died", *Globe and Mail* (April 12 2002):A12; NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Mental Health, Letter to Gee from Roberts, Dec. 21, 1954 and letter to Roberts from Gee, Jan. 4, 1955. The Dec. 21 meeting was between

Roberts, McQuarrie and Percy. The Jan. 4 meeting was between Gee and Mallory.
345. CNA Archives, WY160,C25, "The Preparation of Nursing Personnel for the Care of the Mentally Ill", the Committee on Educational Policy, June, 1954. Prior to this policy paper the CMHA asked the CNA to recommend the affiliation to provincial associations. See Minutes of Executive Committee, Feb. 16, 1952.
346. CNA Archives, WM2, A48I, Advisory Committee on Mental Health, Subcommittee on Training, "Supplementary Report #1 to the Preparation of Nursing Personnel for the Care of the Mentally Ill", May, 1955. This CNA report referred only to Saskatchewan, Alberta and BC psychiatric nurses. Mental hospital nurses in Manitoba organized later in the decade and obtained legislation in 1960. As in Saskatchewan it was sponsored as a private member's Bill. See A. Osted, "40th Anniversary, A Tribute" *Update* (March 2000):3-4.
347. Chris Dooley, "When Love and Skill Get Together: Work, Skill and the Occupational Culture of Mental Nurses at the Brandon Hospital for Mental Diseases, 1919-1946" (Masters thesis, University of Manitoba, 1998): abstract, 213-214.
348. AHCPMH, CMHA, National Office Records: Committee on Psychiatric Mental Health Services, Subcommittee of the Scientific Planning Council (Tyhurst Committee), Working Papers, "Working Paper on Nurses, Aides and Attendants", Dorothy Percy, 1957.
349. WGH Alumnae Archives, Journal Collection, Virginia Lindabury, "Editorial", *The Canadian Nurse* (Oct. 1967):25. This editor was critical that the country's registered nurses were ignoring what was happening in western Canada. She believed that their silence only condoned inadequate psychiatric nursing care in western Canada. The editorial implied that registered nurses in the west were less involved in the care of psychiatric patients because the separate group was dominant in mental hospital care. It was meant to be a wake-up call for Canadian registered nurses about the specialty of psychiatric nursing.
350. Peter Nolan, "Psychiatric Nursing, Past and Present: The Nurses Viewpoint" (Ph.D. diss., University of Bath, UK, 1989), 200-208. The GNC included general nursing with mental nursing.
351. Ibid., 202.
352. Ibid., 197.
353. Olga Church, "That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963" (Ph.D. diss., University of Illinois, 1982), 190-225.
354. Ibid. The National League for Nursing Education became the National League for Nursing (NLN) in 1952. Canadian nursing did not have a national accreditation body with each provincial nurses' association providing approval (or non-approval) to schools. The 71 American schools offered a gamut of diploma, affiliation, postgraduate and auxiliary courses. Of the 71, only 32 offered the three-year diploma. The NLNE wanted accreditation responsibility in order to expand affiliations to mental hospitals. Esther Lucille Brown's 1948 report, "Nursing for the Future" had recommended ending the three-year courses and focusing on affiliations for all students, and thus initiated many of these changes.
355. Ibid. In 1955 the APA gave up its accreditation program and ended its nursing consultant position. Elsie Ogilvie was the final person in the APA consultant's office. Ironically this was just one year after Ogilvie and McKerracher convinced the SRNA that

it had to offer 12 week affiliations at the Munroe Institute. See SAB, SRNA, R1271-94, Educational Policy Committee, Minutes, May 12, 1954.
356. Ibid. The NLNE strongly recommended the psychiatric affiliation beginning in 1950 and by 1954 80% of students in accredited American schools received psychiatric affiliations. Ogilvie made a point of sharing this information with the SRNA and school directors on May 12, 1954. In 1955 the NLN mandated psychiatric nursing for accreditation. This created a problem for Canadian graduates without the affiliation who were attempting to become registered in the United States. The American requirement for psychiatric nursing placed pressure on provincial nurses' associations to mandate and examine psychiatric nursing. Letter from Judith Oulton, Executive Director, CNA, to writer, March 14, 1994.
357. Ibid., 201-208. Conscientious objectors exposed the state hospital conditions to the media. In order to reduce the centrality of state hospitals, new ways of delivering mental health care were promoted. The National Institutes of Mental Health became the centre for research and education.
358. Ibid.
359. Ibid., 239-240. Many of the nurses who studied in psychiatric nursing had served during the war and were particularly interested in the specialty. The GI Bill of Rights also assisted their ambitions.
360. Ibid., 205. The definition of psychiatric nurse was determined by virtue of educational preparation and credentials. Specialty practise was at the master's level. Church refers to psychiatric nursing as a discipline but it was defined as a branch of general nursing.
361. Ibid.
362. Simmons, 87-90. The policies differed in both content and strength. Paul Martin had expressed a concern in 1949 that Canada was falling behind the United States in mental health planning. See NAC, RG29, Vol. 303, File 435-2-3, Mental Health Div., Letter to my dear colleagues from Martin, Oct. 1949.
363. Ibid; Church, 201-208.
364. Simmons, 66-67, 87-90. Dr. Roberts had the final say in all grant proposals and applications for funded courses for nurses. Also see Roberts, 69-89.
365. Ibid.
366. Ibid., 89.
367. Ibid., 90.
368. Perhaps if there had been even one nurse with psychiatric nursing expertise on the mental health advisory committee from 1947 to 1955, education for psychiatric nursing would have developed more smoothly. Ogilvie, off to a good start in 1948, disappeared and Percy, not an expert, stepped into the situation in 1954.
369. NAC, RG29, Vol. 317, File 435-6-4, Pt.3, Subcommittee on Training, Memo to Dr. Roberts from Dorothy Percy, March 3, 1954. Percy had traveled to Ontario and Quebec and received information that the courses were not popular and that changes were required in the funding of registered nurses for education in psychiatric nursing. While there were no graduate nursing programs in Canadian universities until 1959, the mental health grant monies could not be used for baccalaureate nursing programs. AHCPMH, File 10, Statistics, Box 3, "Some Facts About Mental Illness in Canada", Mental Health Division and Dominion Bureau of Statistics, 1957, 28. This document noted that from

1948 to 1957 there were 428 nurses who were helped with post-graduate and a variety of other short courses. For information on the development of graduate nursing education see Janet Ross Kerr and Jannetta MacPhail, "The Changing Face of Nursing Education in Canada" in *Concepts in Canadian Nursing* eds. J. Kerr and J. MacPhail (Toronto: Mosby, 1996), 106-108.

370. Church, 273.

Chapter 7

In Retrospect: The Development of Education for Psychiatric Nursing in Three Canadian Provinces

Introduction

In 1955 psychiatric nursing in Canada split along the Manitoba-Ontario border into two models, one as a specialty within general nursing education, the other as education for a separate profession. This dissertation began with a perplexing question: How did Canadian psychiatric nursing develop into two entirely different models? I have attempted to answer this question by chronicling the development of education for psychiatric nursing in Ontario, Manitoba and Saskatchewan over the fifty years leading to the split. An interplay of social, political and economic factors has emerged which shaped psychiatric nursing's development and influenced the evolution of the two models. Influences also include nursing leadership's action and resistance to medical authority. In retrospect, it is the story of a struggle for the control of education for psychiatric nursing between the leaders of Canadian nursing and medical psychiatry.

This dissertation has concentrated on the processes through which decisions were made. Some of these processes were more important than the outcomes because of what they revealed about nursing, nursing education and the options which were available to nurses in the first half of the twentieth century. Throughout this half-century the same issues arose time and again, and resolution of one critical event led to another,

in time drawing the three provincial systems of education for psychiatric nursing in different directions.

Synopsis of Findings

The Ontario government, in concert with medical superintendents at five mental asylums, initiated a three-year training program for mental nurses in 1909.[1] General hospital training schools had been operating in Ontario since well before the turn of the century but; nevertheless, it had been impossible to obtain trained graduate nurses to work at the government asylums.[2] Training schools were to be a key piece in the province's effort to provide new methods of psychiatric care in a more hospital-like setting.[3]

Training for psychiatric nursing developed under the control of medical superintendents. In spite of the fact that there was little general nursing presence at the male-dominated asylums, organized nursing in Ontario considered mental nurse graduates as eligible for registration, contingent upon their general affiliation.[4] This attempt by the Graduate Nurses Association of Ontario (GNAO) leadership to exert at least some authority over education for psychiatric nursing at the asylums set off an intense and lengthy conflict with the province's medical superintendents, who wished to maintain an apprenticeship approach.[5] The doctors' power and influence extended beyond the doors of their institutions, and their arrogance, combined with political tactics, ensured that the GNAO did not achieve authority over nurse training and registration.[6] The government's heavy involvement with both general nursing and mental hospital administration ensured recognition of the schools and medical psychiatry's

continued control over education for psychiatric nursing. The evidence around this early conflict reflected the gendered perceptions of psychiatrists about the proper role of women and nurses, including nursing's leaders, all of whom were placed in the role of professional subordinates.

Nursing leaders in Ontario did not acquiesce in the doctors' coup. Within a few years of passage of the Registration Act (1922), and citing the need for better psychiatric nursing care, the nurses asked the Ontario government to mandate general affiliations for asylum students.[7] Psychiatrists retained control of the schools. Nonetheless, this nursing victory was critical, for affiliations were key in effecting the professional transition from mental nurse to graduate or registered nurse in Ontario's mental institutions. The nurses' victory enabled them to draw psychiatric nursing education and its students and graduates closer into general nursing and away from the tight grasp of psychiatry.

A decade after education for psychiatric nursing was established in Ontario, and in response to the desperate need for nursing care of mentally ill World War I veterans, the first mental hospital training school west of the Great Lakes was begun in Brandon, Manitoba.[8] In contrast to the Ontario government's mandated and well-regulated mental hospital training school system, training schools established in Manitoba were institution-specific, and developed in a haphazard fashion according to the vision and whims of their medical superintendents.

Manitoba's mental hospital schools were latecomers to the nurse training field in the province. As a result, when one medical superintendent attempted to improve the quality of nursing care at his hospital with a move to include general affiliations, organized nursing reacted swiftly. Like their eastern colleagues, nurse leaders in

Manitoba entered into a struggle with psychiatrists over the control of education for psychiatric nursing. However, unlike their colleagues, instead of concurrently seeking to gain some authority over that education, these leaders secured legislative amendments which made it even more difficult for mental hospital graduates to become registered. Lacking status, medical psychiatry was unable to gain recognition from organized nursing for its training program; and mental hospital students and graduates were effectively excluded from the general nursing scene in Manitoba.[9] It was a missed opportunity with unintended outcomes. In the struggle for control of psychiatric nursing education between organized nursing and medical psychiatry, general hospital boards of trustees were much more powerful than either of these players.[10] As a result, education for psychiatric nursing in Manitoba was pushed back under medical psychiatry's control and the status quo prevailed.

While the 1930's Depression and World War II limited the development of education for psychiatric nursing, the 1932 release of Professor Weir's report, *Survey of Nursing Education in Canada,* nevertheless affected its development.[11] Like most nurse leaders across North America, Weir had been influenced by the mental hygiene movement, and wanted nurses to close the gap between physical and mental illness. He believed that psychiatric nursing was a specialty within general nursing and validated its significance for Canadian leaders. He advocated mental hospital affiliations for all general students, providing organized nursing with a rationale in the struggle with psychiatrists, provincial governments and hospital boards over the control of nursing education.[12] Weir's recommendation for psychiatric affiliations was included in the

Canadian Nurses' Association's *Proposed Curriculum for Schools of Nursing in Canada,* a document that was utilized across the country until well after the war.[13]

By the end of the war provincial governments and mental hospitals in Saskatchewan, Manitoba and Ontario, as elsewhere, found themselves in the midst of a crisis involving too many patients and a severe shortage of students and trained nurses to provide psychiatric nursing care.[14] The war had created a new public, government and health professional interest in mental health care, but above all else, it was the nursing shortage that influenced the approaches taken in the post-war development of education for psychiatric nursing.

In Ontario, nurse leaders intervened in the post-war shortage of mental hospital nurses by committing to mental hospital affiliations for all students and resisting the idea for a separate mental nurse training program that had been proposed by some medical superintendents.[15] By the end of the decade affiliations were quickly overtaking the shrinking enrolments at the six remaining psychiatrist-controlled mental hospital schools.[16] Organized nursing was setting the direction and clearly attempting to gain full control of education for psychiatric nursing in the province. The results were mixed. Increased affiliations required increased student accommodation. Student nurses provided the majority of care to female patients at Ontario's mental hospitals and were considered a valuable asset. However, whether they were general affiliates or mental hospital students, as females they held little status and their marginal position meant that finite government resources were not designated for student accommodations. There was a lack of government will.[17] Organized nursing in Ontario was not able to make the psychiatric

affiliation a requirement for registration because of gender discrimination and a lack of authority over the education of its students.

In Saskatchewan, not only was a new training program initiated by psychiatrists, but in 1948 the provincial government created a new occupation of psychiatric nursing that licensed trained attendants.[18] This marked a crucial point in the development of education for psychiatric nursing, not only for Saskatchewan but for the whole country. Besides the shortage of trained nurses, several factors led to this moment. These included: the vice-like control of mental hospital apprentice-style staffing by medical psychiatry for as long as the mental hospitals had operated; a new social democratic government that was undertaking health and mental health care reform; and the refusal by nursing leaders to compromise standards of education in their attempt to resist psychiatry's takeover of education for psychiatric nursing.[19] Strong nursing leadership, however, was unable to withstand political maneuvering, the paternalism of the period and the powerful collusion of unionized male attendants and male legislators. Saskatchewan nurses lost affiliations and education for psychiatric nursing because they were women and nurses, and as subordinates, held very little authority amongst men. It was not then evident, but general nursing's loss of specialty education for psychiatric nursing in Saskatchewan and the creation of the separate and distinct occupation, foreshadowed an identical situation at the national level.

The chronic post-war shortage of trained mental hospital nurses and tensions between some mental hospital nurses in the west moved education for psychiatric nursing onto the national agenda, and for the first time it received sustained attention from both the federal government and the Canadian Nurses Association (CNA).[20] An intense and

often ruthless battle took place between nurse leaders, medical psychiatry and the federal government over the control of education for psychiatric nursing. Study after study recommended the utilization of trained mental hospital auxiliary workers as an interim measure to deal with the nursing shortage.[21] However, through poor judgement, collusion, indiscretions and the abuse of power, psychiatrists and federal government officials turned that recommendation into the separate Western Canadian training model. Nurse leaders were excluded from the table where critical decisions about nursing education were made. Medical psychiatry attempted to extend its monopoly on psychiatric nursing education eastward, and Canadian nurses were requested to accept the Western Canadian definition of psychiatric nursing as a separate and distinct profession.[22] It was a paternalistic and arrogant method of attempting to subordinate female registered nurses. The stakes in this power struggle were high and Canadian nurses came close to losing all control of education for psychiatric nursing and the specialty to Western Canadian psychiatrists. A crucial point came in 1955 when well-educated nursing leaders thwarted the medical takeover by simply refusing to endorse the Western Canadian apprenticeship model of education as appropriate for all of Canadian nursing.[23] The monopoly over education was cracked. The eastward movement of the distinct doctor-controlled Western Canadian model for psychiatric nurse training was halted by these nurses at the Manitoba-Ontario border. However, a concomitant, genuine attempt to embrace and pull Western Canadian psychiatric nurses under general nursing's umbrella failed miserably.[24] That lost opportunity had startling, unintended outcomes. What had earlier threatened to become a national problem for nursing–a separate nursing occupation under medical psychiatry's control–remained an issue only for Canada's three

westernmost nurses' associations. That education for psychiatric nursing would "part at the crossroads" between Eastern and Western Canada was not envisioned by the nurse leaders. In Manitoba, education for psychiatric nursing had resembled both regions' models but lacking general nursing's leadership, eventually tilted toward the separate western model.

Inroads at the national level did not translate into a similar success at the provincial level. In Manitoba, Ontario and Saskatchewan, organized nursing continued to have minimal or no control over education in psychiatric nursing provided for general students. For the most part, that education remained at geographically distant and culturally distinct psychiatrist-administered provincial mental hospitals. Nurse training was initiated by medical psychiatry and fifty years later its development remained shackled by those origins. Thus, while the nurse leaders had put some cracks into the doctors' monopoly over education, the monopoly was not broken. Characteristics of mental hospitals and general hospital training made it impossible for the three provincial nurses' associations to mandate education for psychiatric nursing. That would take another fifteen years and further struggles.[25]

Just as it has illustrated the gap between the environments of mental and general hospitals, this study has revealed much more about the development of education for psychiatric nursing from the perspective of nursing's leadership. It has said less about the perspective of mental hospital students and nurses. Nevertheless, the evidence shows that most young women who trained at mental hospitals were white, Canadian-born and of British, Scottish or Irish descent. The majority came from rural, working class families and were induced to enter mental hospital training for economic reasons. Their numbers

were small and their workload horrendous as they trained under the all-encompassing authority of medical superintendents. In spite of the heavy work and long hours, they enjoyed the family-like atmosphere of the mental hospital community and reflected positively upon their training. For many, this training was a step on the way to general hospital training or work. As they attempted to gain authority over education for psychiatric nursing, nurse leaders were the voices for these mental hospital students and nurses. The evidence supported that nursing leadership was consistently concerned about the quality of the specialized education and the students' career prospects. Unlike the well-documented power struggle between nurse leaders and medical psychiatry, little documentation has survived dealing with the relationship between nurse leaders and mental hospital students and nurses.

What do these findings mean in terms of nursing history? This study mirrors themes in the development of general nursing education. The lack of control over education which surfaced time and time again in this study is a perennial nursing issue. However, as America's first psychiatric nursing professor, Effie Taylor observed,[26] the interprofessional tension between nursing and medical psychiatry was exceptional. When she was superintendent of nurses at Johns Hopkins Hospital she complained to Adolf Meyer, medical director at the hospital's Phipps Psychiatric Clinic, that her student nurses disliked working at the clinic because the psychiatrists did not value nurses. She wrote:

> This criticism has spread beyond our school and beyond the city and it has been made a matter of comment at conferences of professional people interested in the education of women for public health, mental hygiene and social work. I want to tell you, however, that I made it clear that it was not because the nurses had lost their ideals but because of a failure on the part of the medical staff to co-operate with the nurses' education. Why the

> physicians in this department, more than in any other, should feel that the function of a nurse is that of a hand maiden to the physician...is more than I can understand. It is the greatest insult to the intelligence of nurses.[27]

Taylor's observation reflected the ambiguous and subordinate status of nurses generally; and more specifically, it showed that in their professional relationships with psychiatrists, nurses were challenged by a dominant psychiatric authority. Historians have pointed out the status differential which existed between mental hospital medical superintendents and their medical colleagues. The superintendents were not perceived to be practising medicine because their treatments were ineffective. To compensate for this lack of respect, they amplified their authority at the mental hospitals and in all non-medical relationships, including with government officials and general nurses.[28] They had a monopoly over education for psychiatric nursing because they started the schools and training was on their turf. The pattern so clearly evident in this study was that an amplified psychiatric authority intersected with the gendered limitations of female nurse leaders as they attempted to gain control of education for psychiatric nursing. Education for psychiatric nursing developed in an uneven and erratic fashion in Ontario, Manitoba and Saskatchewan and even split into two models because organized nursing did not control this specialty education or nursing education overall.

Considering the power wielded by the psychiatrists and the gendered limitations of the nursing leadership, it might have been easier for the nurses to give up the struggle and allow medical psychiatry to maintain its traditional tight control of education for psychiatric nursing. But these nurse leaders clearly understood the implications of the growing psychiatric monopoly; and determined about how they wanted students to be educated for psychiatric nursing, refused to be victims. Effie Taylor and American nurse

leaders who came later, moved psychiatric nursing education to university settings, and the Canadian nurse leaders refused to allow the specialty of psychiatric nursing to be taken over by an expanding psychiatric monopoly. Simply put, the stakes were high and they exerted power despite the relative lack of power in their hands. The nurse leaders were not always victorious. Along the way there were some far-reaching unintended outcomes and errors. That they persevered in the enduring struggle to gain authority over education for psychiatric nursing was a remarkable contribution to the overall development of nursing education in Canada.

Implications for Nursing Education

There are implications for nursing and nursing education to be found in this study. Remnants of the themes outlined above survive to the present as organized nursing continues to struggle with issues around autonomy and authority over education and practise. What seems new to us is not without precedent. The attempt by psychiatrists and the federal government to introduce a new Western Canadian education model to ameliorate the country's mental hospital nursing shortage in the 1950's, does not greatly differ from the recent struggles between organized nursing and provincial governments in Manitoba, Saskatchewan and British Columbia over the type of nursing education, diploma or degree, which could best address the current nursing shortage. In all three western provinces, at issue was how nursing students were to be educated.[29] Nursing was and is primarily a women's profession; and issues of gender and the value placed on nursing as an academic discipline relative to more traditional disciplines, cannot be dismissed. To assert control over education is the mark of an established profession, and

at the beginning of the twenty-first century it is distressing to realize that the struggle for authority over nursing education remains. Writing about the historical development of education for psychiatric nursing in the midst of a raging debate about nursing education was a challenging task. With the losses experienced in the current struggles it might be tempting for organized nursing to take on the role of passive victim. However, what needs to be appreciated from this study's findings was the extraordinary determination and persistence shown by nursing leaders in identical struggles. The challenge, then, of continuing the development of nursing education is the responsibility of the profession, and the current generation of nurses and its leaders must assert control and contribute to that process. It is time to transform distress into action.

On a more cautionary note, if there is any lesson to be learned from nursing leadership's struggle for control of psychiatric nursing education, it is that of "unintended or accidental outcomes". Although nurse leaders won the battle with psychiatrists, first in Manitoba, then at the national level, mental hospital students and nurses remained under medical psychiatry's tight control in the western provinces. On the other hand, Ontario's nursing leadership conjointly embraced and nurtured mental hospital students and nurses even as they battled medical psychiatry, with significantly different outcomes. Therefore, as organized nursing seeks to control the development of its education, students and nurses who will significantly be affected must be included in the process.

Implications for General Nursing Curricula

There are implications from this study which relate specifically to education for psychiatric nursing in current and future Canadian nursing curricula. Similar to what is

occurring in the United States, new nursing curricula are being designed using an integrated model in which the structure of the curriculum is based on concepts. Traditional curricula were designed using discrete bio-medical based courses.[30] However, there is a significant amount of new content vying for inclusion in baccalaureate programs and practical challenges to devoting large portions of programs to any one specialty. Psychiatric nursing has been a discrete course in traditional curricula; but in an integrated model, while concepts from psychiatric nursing's theoretical base are present, they are not distinct. An integrated curriculum is said to be leading edge and assists students to learn in a more holistic manner. At the same time, gaps in core knowledge are a potential problem.[31]

Numerous American psychiatric nurse educators have suggested that the integrated curricular model has resulted in a decrease in the number of graduating students who choose to pursue careers in psychiatric nursing.[32] There is some question as to the amount of integrated content that students actually learn as distinct "psychiatric nursing". Psychiatric nursing as a specialty of nursing has become "invisible" in many curricula; and with reduced exposure fewer students perceive it as an option.[33]

While there is not yet any Canadian evidence which points to a similar decrease in graduates choosing this specialty, the Canadian Federation of Psychiatric Mental Health Nurses (CFPMHN) is concerned about the quantity and quality of undergraduate education for psychiatric nursing, and implications for patient care. In some curricula nursing students no longer receive a clinical experience in psychiatric nursing.[34] The CFPMHN has recommended to Canadian university schools of nursing that psychiatric nursing remain a distinct theoretical and clinical course.[35]

How ironic it is that the decreased attention to education for psychiatric nursing has occurred against a backdrop of a growing awareness in North America and elsewhere, of the immense burden of disability associated with mental illness and of the intertwined relationship between mental and physical health.[36] The World Health Organization has predicted that a "dramatic increase in mental illness is just around the corner"[37] and the International Council of Nurses (ICN) recently recommended that "all nurses must have the knowledge and skills to be able to respond to peoples' mental health needs".[38] To meet the health care needs of the population in the early decades of the twenty-first century, it is apparent that graduating nurses will require content in psychiatric nursing to effectively engage in nursing practise.

While other specialty courses in integrated nursing curricula also are not visible, for example obstetrical and pediatric nursing, such courses did not experience the same struggle for inclusion within nursing education as did psychiatric nursing. Education for psychiatric nursing was created by psychiatrists and taught separately from most nursing programs; and the primary reason that nursing leaders battled to gain control of that education was because without it, registered nurses were neither interested nor competent in caring for mentally ill patients. Committed nurse leaders such as Kathleen Ellis, Nettie Fidler and Elizabeth Bregg struggled mightily with this issue because they believed the course was vital to improved psychiatric and general nursing care.[39]

Today's psychiatric nursing educators are not indifferent to this history and have raised some red flags. Stuart has warned that educators must take even more responsibility for the plight of the specialty and its patients by educating colleagues and by advocacy. It is a unique specialty, she suggests, and not merely a concept for cutting

edge curricula.[40] Simply put, the passion for this specialty has to be ignited during a nurse's education. Is it timely then, for Canadian educators of psychiatric nursing to draw upon the legacy of our nursing leaders' struggles for this education. They entered these struggles for a reason and never stopped trying. As Stuart asks: "If not us, then who?"[41]

Implications for Psychiatric Nursing in Western Canada

Almost fifty years have passed since education for psychiatric nursing split along the Manitoba-Ontario provincial border into two models, and developed in a parallel fashion. Nevertheless, interactions between that tension-filled past and the present are evident, particularly in Western Canada, where the two models of education co-exist. In that region there are registered nurses who have been educated in general nursing and practise in the nursing specialty of psychiatric nursing, and registered psychiatric nurses (RPN) who have been educated in and practise in the separate profession of psychiatric nursing.[42] Notably, both groups utilize an identical theoretical and research base, much of which has been developed by American psychiatric nurses. Most textbooks, too, have been written by American nurses.[43]

From time to time tensions from the past reemerge. Not surprisingly, the terminology issue remains a confusing one, particularly around ownership of the seemingly generic term "psychiatric nursing" and exactly "who" are psychiatric nurses. Dorothy Percy once declared that nobody "owned" psychiatric nursing.[44] However, in Western Canada the designation is legally protected and belongs to the separate profession.[45] The generic term is also utilized by some RNs with certification in the specialty.[46] Government officials and employers most often utilize the generic term when

referring to either the specialist (RN) or the separate professional (RPN).[47] Individuals from the two nursing groups practise side by side and their patients also refer to them by the generic term. Each group holds separate professional conferences but both display the same generic term in the conference titles.[48] When tensions arise over terminology it most often is initiated by the professional RPN associations, which promote the legality and distinctiveness of the separate profession.[49] However, since the separate profession utilizes a theoretical and research base which has been developed by American registered nurses, that distinctiveness is ambiguous. The RPN associations might further emphasize their distinctiveness and decrease terminology confusion by promoting use of the full professional designation, registered psychiatric nurse(ing), in all endeavours.

A related tension which occasionally reappears is the lack of regard for RNs on the part of some past Western Canadian psychiatrists. Some of that was modeled and passed on through two generations of RPNs. While less harsh now, it most often involves concerns around the credibility of RNs as employees in psychiatric nursing positions and general nursing students as learners in psychiatric settings.[50] This contextual issue should be dealt with in an explicit manner by psychiatric nurse administrators, practitioners and educators in Western Canada. It is a non-issue east of Manitoba and in the United States.

And finally, it is highly significant that in Saskatchewan, birthplace of the separate profession, RPN education and general nursing education have united in one four-year nursing program. Upon successful completion of the bachelor of science in nursing degree program, students are eligible to write one or both registration examinations.[51] The rationale for the separate RPN profession joining forces with general nursing in this new program was to ensure a broader preparation for students and

improved employment prospects. Prior to this venture there had been concerns that graduates were not recognized beyond Western Canada.[52] And once again, what seems new is not without precedent, for this program is not much different from the one attempted by Evelyn Mallory and colleagues in the mid-1950's. When it failed and western psychiatric nurses lost a chance to obtain their RN, Dorothy Percy wrote: "It is hoped that an idea that has much to recommend it may at the right moment be realized".[53] While the impact of the current joint venture on psychiatric nursing in Saskatchewan is not yet known, it could eventually serve as a model for nursing education in the western provinces.[54]

Future Research

This study has been a pioneering effort to document the development of education for psychiatric nursing in three Canadian provinces. Much more data exist than were known or expected when the study commenced. The history was larger and more complex than initially assumed and necessarily goes beyond psychiatric nursing itself. It is related to the histories of Canadian nursing and psychiatry and those dimensions are only suggested here. Obviously much more research is needed. For instance, the relative influences of regionalism, provincial jurisdiction and class analysis should be considered in future work.

To amplify the historical picture, more evidence is required from mental hospital students and nurses. One suggestion would be to carry out a similar exploration in one or more provinces east of Ontario. The Nova Scotia Hospital in Dartmouth established a training school prior to the turn of the twentieth century and it operated until 1970.[55] It would be especially relevant to include oral histories from nurses who trained and

worked at this institution, and compare their stories with those of the retired Ontario, Manitoba and Saskatchewan mental hospital nurses. For instance, were they predominantly white, rural, working class women and was their rationale for training at the mental hospital mostly financial? What were the relationships between Nova Scotia's nursing leadership and mental hospital students and between the leaders and medical psychiatry?

In the current study, the inclusion of students and nurses as well as nurse leaders shed better light on psychiatric nursing's development. Although Mansell asserts that research based primarily on documents written by nursing leaders is incomplete,[56] this study would be incomplete without the use of such records. The mental hospital students and nurses left little written documentation. Bramadat argues that research utilizing the records created by nurse leaders provides valuable insights into the forces which shaped current nursing issues, and ought not to be minimized.[57] In this study, it was shown that students and nurses trained and worked under the medical superintendents' control and their status was only marginal. While their milieu was different, the nurse leaders who struggled for control of education for psychiatric nursing were similarly challenged by gendered limitations and a lack of authority over nursing education, issues which have endured to the present.[58] Thus, while I did not set out to interpret psychiatric nursing's history from a professionalization perspective, the data revealed that professionalization played a central role.

Methodologically, there are some issues concerning the consent for oral history interviews which could be considered. Two retired nurses initially consented to this study (appendix D), but upon reviewing their audiotapes, declined to have their oral histories

placed in the Provincial Archives of Manitoba. At the time of the second consent in the two-step consent process (appendix E), these interviewees restricted access to the researcher and requested that their interviews remain confidential. One nurse explained that after listening to her tape (two months post-interview), she worried that some of her statements could be misinterpreted by individuals currently employed at her former workplace. She was not interested in having these parts of the tape and transcript edited. The other interviewee did not reveal her rationale for restricting access.

In an oral history project with Alberta psychiatric nurses, Boschma, Yonge and Mychajlunow also experienced some difficulties gaining the second consent. In their study, consent involved reading and understanding the written transcript (as opposed to the audiotape). The researchers believe that it was the combination of the review of the transcript and the authorization to deposit that made the second consent a complex process. As well, ambivalence was created by obtaining the consent to deposit at this later date.[59] Instead, they suggest that at the time of the initial consent and interview, the authorization to deposit the oral history, including any restrictions, could be included. The second consent could be used simply to confirm that the interviewee had read the transcript and was offered an opportunity to make corrections.[60] Since oral history includes making public the account given, this advice to simplify the consent process and to handle the review in a timely manner is relevant to future research.

In 1954 Elizabeth Bregg harshly predicted that the newly created occupation of psychiatric nursing in Western Canada would negatively affect the development of the specialty of psychiatric nursing.[61] Just how the specialty developed following the split of education into two models needs to be examined, both in Ontario and in one or more

western provinces. However, future researchers are forewarned that a history of the specialty's development will be incomplete unless it is studied hand-in-hand with the western profession's development, as was carried out in the current study. The significance of this study is that the data were woven together from numerous and diverse archives which hold sources of information about both groups of nurses. The analysis showed that an interplay of factors shaped this history. This approach illuminated the issues and increased the validity of the findings. In Canada, psychiatric nursing did not develop as a seamless monolith, and there is too much shared history to study only one part. Not surprisingly, this intricate approach complicated the study and lengthened the time needed to conduct the research, but it assured a fuller understanding.

An exploration of the period after 1955 could more readily focus on the nurses who trained and worked in both the specialty and profession. Psychotropic medications were first used in Canadian mental institutions from 1955 and held great promise for patients and their nurses.[62] What changes, if any, occurred in education and practise in conjunction with the new medications? Further, the locus of psychiatric care changed dramatically in the two decades after 1955.[63] In the final years of the current study, nursing leaders pinned their hopes for improved and mandatory education for psychiatric nursing on the creation of more general hospital psychiatric wards. What changes, if any, took place in education and practise when the locus of care changed? How did nurse leaders obtain more authority over that education?

The findings from this study raised some intriguing questions about the regional variations in the roles played by men in psychiatric nursing.[64] In Ontario, there was general resistance to the education of males for psychiatric nursing and never more than a

handful trained at the mental hospitals. Their impact on the development of the specialty of psychiatric nursing was not significant prior to 1955. Further, there was a clear distinction between attendants and trained nurses in that province's institutions.[65] Conversely, the findings indicated that unionized males in Saskatchewan played a noteworthy historical role in the development of the separate psychiatric nursing occupation. In Saskatchewan, the line between trained attendant and psychiatric nurse was indistinct, and marginalized male attendants readily made the transition to psychiatric nurse. The evidence suggested that patriarchal gender perspectives which reflected a high valuation of all that was male played a significant role in the new occupation's development.[66] The impact of unionism on the profession's emergence in Saskatchewan should be explored. Historical research on Canadian men in nursing, including psychiatric nursing, is minimal, and an exploration of the transition from male attendant to psychiatric nurse in Saskatchewan and the other western provinces would be invaluable.

And finally, it would be of interest to examine further the lives and work of the nurses who played instrumental roles in the development of Canadian psychiatric nursing. In the United States, Hildegard Peplau is known as "the mother" of psychiatric nursing,[67] and while that honor does not apply to any one nurse described in this study, several contributed, though the results of their efforts were sometimes mixed. Nurses such as Kathleen Ellis, Elsie Ogilvie, Nettie Fidler, Elizabeth Bregg, Evelyn Mallory, Edith Pullan and Dorothy Percy were leaders who displayed a high level of commitment to the development of education for psychiatric nursing for Canadian nurses and their patients.[68]

Dr. George Stevenson, Ontario psychiatrist and long-time champion of the Canadian nursing profession and its autonomous education, wrote in 1935: "When the history of nursing during the twentieth century is written, this accomplishment will rank high".[69] By "this accomplishment" he was referring to education for psychiatric nursing as an integral part of nursing education. How Stevenson's prediction played out in the half-century after 1955 has yet to be written.

Notes

1. AO, Government Documents, PS Microfiche, Edward Ryan, "Training Schools for Nurses at Ontario Hospitals for the Insane", *Bulletin of the Ontario Hospitals for the Insane* IV, I(1910):13-17.
2. Hamilton Psychiatric Hospital Archives, Books, Uncatalogued, A. Richardson, "Nurses in Hospitals for the Insane", in *Proceedings of the Fifty Eighth Meeting of the American Medico-Psychological Association*, Vol. 9 (Montreal, Quebec, June 17 1902), 212-222.
3. AHCPMH, Nursing, Psychiatric, "Trained Nurses for Asylums", *Toronto Star* (July 9 1906).
4. CNA Archives, Journals, Graduate Nurses' Association of Ontario, "Second Meeting of the Graduate Nurses' Association of Ontario", *The Canadian Nurse*, 1,2 (1905):11-20.
5. AO, RG8-9, File 2.18, Box 2, Letter from Dr. C.K. Clarke, Toronto Asylum, to Hon. J.P. Whitney, MP, Assistant Provincial Secretary, April 21, 1906.
6. CNA Archives, Journal Collection, Julia Stewart, "The Inception and Development of the Graduate Nurses Association, Ontario, 1904-1926", *The Canadian Nurse* (Feb 1928):64-71.
7. CNO Archives, Council of Nurse Education, Waiver File, 1923, Letter from E. MacPherson Dickson to superintendents of nurses, Ontario Hospitals, Aug 1.
8. PAM, "Brandon Hospital for Mental Diseases, Annual Report", 1921, 5-6.
9. PAM, RG18B2, Box 3, Public Works, Deputy Minister, File: Brandon Mental Hospital, 1921-27, Letter from Baragar to Mathers and McClean, Feb 15, 1927.
10. Ibid.
11. George M. Weir, *Survey of Nursing Education in Canada* (Toronto: MacMillan Co., 1932).
12. Ibid., 299. Also see Olga Church, "That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963" (Ph.D. diss., University of Illinois, 1982), 81-165. Church describes how the needs of the nurse leaders for psychiatric affiliations contrasted with the needs of medical superintendents for mental nursing service.
13. WGH Alumnae Archives, Curricula, "A Proposed Curriculum for Schools of Nursing in Canada", Canadian Nurses Assoc., 1936.
14. Donald Le Bourdais, "Canada's Shame: Our Mental Hospitals, Part 2, The West", *Liberty* (Feb 8 1947):8,9, 38-41; "Part 3, Ontario and Quebec", *Liberty* (Feb 25 1947):8,9, 34-38.
15. CNO Archives, Council of Nurse Education, Book 3, Minutes, June 17, 1948; AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting Sept 30, 1947, Report from the Special Committee on Psychiatric Nursing, July 10 and Sept 5, 1947.

16. CNO Archives, Council of Nurse Education, Book 3, Minutes, June 17, 1948.
17. AO, RG10-20-A-1, File 1.2, Superintendents' Conferences, Minutes, 1945-49, Meeting, May 6, 1949. The Ontario government was reluctant to spend money on mental hospital care, and economically and politically marginalized student nurses were a low priority. For a thorough look at the Ontario situation, see Harvey Simmons, *Unbalanced: Mental Health Policy in Ontario, 1930-1989* (Toronto: Wall and Thompson, 1990), 243-246. Simmons found that what got built in the mental hospital system had to provide some political benefit for government.
18. SAB, R594, Box 22, Session 1948, 5th Session of 10th Legislature.
19. SAB, SRNA, R-993, 43F (4.2-9), Letter to Dean Lindsay, Chairman, Board of Examiners, from K. Ellis, Jan 13, 1949. Ellis continued the struggle for control even after the new profession was created by the government.
20. NAC, RG29, Vol. 315, File 435-6-2, Pt.3, Advisory Committee on Mental Health, Points for Minister's Address at Meeting, Oct 25-26, 1948; CNA Archives, Minutes of Executive Committee, Nov 2, 1951 and Feb 14, 1952. The CNA executive was nudged into the education for psychiatric nursing issue and the shortage simultaneously.
21. NAC, RG29, Vol. 905, File 438-5-1, Mental Health Division, Survey of the Nursing and Attendant Situation of the Mental Hospitals of Canada, 1947; Vol. 317, File 435-6-4, Subcommittee on Training, Memorandum to the Subcommittee, from Edith Kemp, Feb 22, 1953; CNA Archives, WY160, C25, "The Preparation of Nursing Personnel for the Care of the Mentally Ill", Committee on Educational Policy, June, 1954. All three reports also recommended increased mental hospital affiliations for general student nurses and viewed this as the eventual solution.
22. CNA Archives, Minutes of Executive Committee, June 6, 1954. Attached were minutes of April 5-6 meeting written by Dr. Roberts. Also see WGH Alumnae Archives, Journal Collection, Charles Roberts, "Nursing the Mentally Ill", *The Canadian Nurse* (Nov 1954):878-83.
23. NAC, RG29, Vol. 318, File 435-6-4, Pt.4, Letter to Dr. Gee from Roberts, Dec 21, 1954 and letter to Roberts from Gee, Jan. 10, 1955.
24. NAC, RG29, Vol. 1690, File 437-11-5, Pt.1, Subcommittee on Training, A Summary of Psychiatric Nursing, 1960.
25. Prior to 1970, each provincial nurses' association made their own arrangements for testing students prior to registration. Some included a psychiatric nursing component but others did not. Whether it was tested usually depended upon whether all students had received the psychiatric nursing experience. Without the experience, it was impossible to mandate psychiatric nursing for registration. In 1970 all provinces utilized the CNA's first registration examination, which included a separate psychiatric nursing component. Some provinces took until 1970 to mandate the psychiatric nursing affiliation for all students. Letter from Judith Oulton, Executive Director, CNA, to writer, March 14, 1994.
26. K. Buckwater and O. Church, "Euphemia Jane Taylor: An Uncommon Psychiatric Nurse", *Perspectives in Psychiatric Care* 17 (1979): 127-128. Taylor was a Johns Hopkins graduate. She left Johns Hopkins and the Phipps in 1923 for Yale University and in 1926 became the world's first psychiatric nursing professor. She later became dean of the school of nursing.
27. Gerald Grob, *Mental Illness and American Society 1875-1940* (Princeton:

Princeton University Press, 1983), 244-245. Grob used this example in his chapter on mental health professions. His original source was noted as Meyer Papers.

28. Ibid. Also see Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Toronto: John Wiley & Sons, 1997)65-68.

29. Doug Nairne and Alexandra Paul, "Province Brings Back Diploma Nursing Plan", *Winnipeg Free Press* (Winnipeg: WFP, Jan 29, 2000): A12. Health Minister Dave Chomiak stated: "The bottom line out of all this is to provide more nurses. That's what we need desperately". Also see e-mail to deans, directors, chairs and faculty, CAUSN, from Entry to Practice Coalition of British Columbia, Jan 2, 2002. Doris Callaghan, Coalition Chair, wrote in this e-mail that Premier Gordon Campbell was moving away from the baccalaureate degree in nursing as entry to practise. The explanation to the profession was "to improve the provision of health services in BC and to ensure that government expenditures on health care are sustainable". For the Saskatchewan situation see e-mail to Karen Wall, Chair, Nursing, Red River College, from Dean Yvonne Brown, College of Nursing, University of Saskatchewan, Jan. 26, 2000. Brown explained that Pat Atkinson, Health Minister, planned to restore diploma education in Saskatchewan. The government was prepared to remove the SRNA's right to set educational standards. Brown called it a "fiasco".

30. L. Finke and D. Boland, "Curriculum Designs", in *Teaching in Nursing: A Guide for Faculty* eds. D. Billings and J. Halstead (Toronto: W.B. Saunders, 1998), 117-134.

31. Ibid.

32. Susan McCabe, "Bringing Psychiatric Nursing into the Twenty-First Century", *Archives of Psychiatric Nursing* XIV (June 2000): 109-116; Tom Olson, "Fundamental and Special: The Dilemma of Psychiatric Mental Health Nursing", *Archives of Psychiatric Nursing* (Jan 1996):3-10; Gail Stuart, "Psychiatric Nursing: A Specialty in Spasm", *Journal of the American Psychiatric Nursing Association* (Feb 2002): 1-2. These educators state that only one percent of new graduates choose the specialty at graduation, down from three percent a decade ago.

33. Ibid. Also see Margaret Jordan Halter, "Stigma in Psychiatric Nursing", *Perspectives in Psychiatric Care* (Jan 2002): 23-29. The writers noted that reduced undergraduate exposure has decreased graduate level interest in the specialty as well as employment interest.

34. CFMHN, *Essential Psychiatric Mental Health Nursing Education for Entry-Level Nursing Programs in Canada* (Toronto: CFMHN, 1999). Much of the data were anecdotal and a study is needed which can examine how much students are learning about psychiatric nursing care in Canadian nursing programs.

35. Ibid. The document was distributed by the CFMHN to all university schools of nursing. The CFMHN is a CNA interest group with members across Canada.

36. USA Dept. of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: USA Dept of Health, 1999).

37. No Author, "Mental Illness Rate on Increase: WHO Study", *Globe and Mail* (Toronto, G&M, May 5 2000): A9.

38. ICN, *Position Statement on Mental Health and Psychiatric Nursing* (Geneva: ICN, 1996).

39. See for example WGH Alumnae Archives, Nettie Fidler, "Psychiatric Nursing",

The Canadian Nurse (Nov 1933):571-78. The second reason was to improve the quality of education in psychiatric nursing by drawing it into general nursing education. Leaders in North America believed that is was unfair to students to be educated in a separate specialty at the undergraduate level. The belief was that it harmed their career prospects.

40. Stuart, 2. The writer was using sarcasm to make her point.

41. Ibid.

42. Until recently most Canadian general nursing students received a separate psychiatric nursing theory course and about 100 hours of clinical practise. Such a course allows new graduates to obtain employment in this nursing specialty. Upon further practise and study, nurses in this specialty can choose to write CNA-administered certification examinations. If successful a nurse could claim to be "certified in psychiatric mental health nursing in Canada" (CPMHNc). At the graduate level, some nurses individualize their Canadian nursing programs to focus on psychiatric nursing and further develop their expertise in the area. Alternatively, some choose to study psychiatric nursing in American graduate nursing programs.

43. A longstanding goal of the separate western nursing profession has been to develop its own unique psychiatric nursing theoretical base. Without this they are forced to utilize theory which has been developed by American RNs in the specialty.

44. AHCPMH, CMHA, National Office Records: Committee on Psychiatric Mental Health Services, Subcommittee of the Scientific Planning Council (Tyhurst Committee), Working Papers, "Working Paper on Nurses, Aides and Attendants", Dorothy Percy, 1957. She was referring to turf issues between RNs and RPNs.

45. That which is protected by legislation is the professional designation "psychiatric nurse or registered psychiatric nurse", depending upon the province. The executive directors of the four western associations incorporated as Registered Psychiatric Nurses of Canada, for administrative purposes. Notably, the title is not "of Western Canada".

46. Canadian nurses who are certified in psychiatric mental health nursing (CPMHNc) often refer to themselves and are hired as "psychiatric nurses". That is what they are east of Manitoba. See for example "Career Opportunities for Psychiatric Nurses in Kenora", *Globe and Mail* (Toronto: G&M, Jan 10 2000). In Western Canada nurses who are CPMHNc also refer to themselves as "psychiatric nurses" but never registered psychiatric nurses.

47. See for example, Jan Currie, "Nursing Story Does Great Disservice", Letter to Editor, *Winnipeg Free Press* (Winnipeg: WFP, Feb 4 2002). Currie used the generic term "psychiatric nurses" in her letter implying both RNs and RPNs. Also see an advertisement in the *Winnipeg Free Press* for the Victoria General Hospital, "Psychiatric Nurse, Full Time". Eligible for registration with the College of Registered Nurses of Manitoba or the RPNAM (2002).

48. For example the Canadian Federation of Psychiatric Mental Health Nurses offered "Psychiatric Nursing into the Millennium, International Psychiatric Nursing Conference", Oct, 2000, Saskatoon. The four western RPN associations offered "World Congress for Psychiatric Nurses", May, 2002 in Vancouver.

49. See for example Annette Osted, "Provincial Nursing Task Force", *RPNAM Update* (Winnipeg: RPNAM, March 2000):8. Osted, Executive Director, reported that RPNs were being lumped in with RNs in the employment picture, and placed them at a

disadvantage.

50. See for example the president's message in the *Canadian Federation of Mental Health Nurses Newsletter* (Calgary: CFMHN, Autumn 1998):4. It was noted that in some western provinces registered nurses were being excluded from some psychiatric nursing positions. In Manitoba, RPNs from the Brandon area petitioned against RNs being hired into psychiatric nursing positions. See "Executive Committee Meeting Highlights", *RPNAM Update* (Winnipeg: RPNAM, June 1996):2. As an educator, I have experienced situations in which general nursing students have been denied clinical access to both urban and rural Manitoba psychiatric settings.

51. Susan Taylor Wood "Changing Times: A Historical Review of Psychiatric Nursing Education in the Province of Saskatchewan" (Master's Thesis, University of Regina, 1998), 91-95.

52. Ibid., 92-93.

53. Dorothy Percy, "Historical Aspects of the Role and Function of Nursing Services in the Department of National Health and Welfare", *Medical Services Journal Canada* 23 (1967):1461-1486.

54. Although the outcomes have not been evaluated, not all the western RPN associations support the new Saskatchewan initiative. Graduates of the program are not eligible for registration in Manitoba and Alberta because the program is said not to have adequate psychiatric nursing content and practise. Annette Osted, phone interview by writer, July 10, 2002.

55. *Nova Scotia Hospital: Special Edition, 1858-1983* (Dartmouth: Publisher Unknown, 1983).

56. Diana Mansell, "Sources in Nursing Historical Research: A Thorny Methodological Problem", *Canadian Journal of Nursing Research*, 27 (Fall 1995):83-86.

57. Ina Bramadat, "Nursing History: Some Issues and Insights", Guest Editorial, Canadian Journal of Nursing Research, 27 (Fall 1995): 13-14. For a similar view, see Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Toronto: John Wiley Inc., 1997), vii-ix. Shorter explains that his research used a social history approach. He attempted to recapture the lives of major players in medical psychiatry and found that their work was not just about medical triumphs and progress.

58. In my study, a great deal was learned from the nurse leaders' records, providing insight into factors which influenced today's nursing issues. To that end, it is not necessary for researchers to "apologize" for using documents created by nursing's leadership. Writers who have examined these enduring issues include: Thetis Group and Joan Roberts, *Nursing, Physician Control and the Medical Monopoly* (Indianapolis: Indiana University Press, 2001); Ellen Baer, Patricia D'Antonio, Sylvia Rinker and Joan Lynaugh, *Enduring Issues in American Nursing* (New York: Springer Publishing Co, 2001).

59. Geertje Boschma, Olive Yonge and Lorraine Muchajlunow, "Consent in Oral History Interviews: Unique Challenges", *Qualitative Health Research* (in press).

60. Ibid.

61. WGH Alumnae Archives, Journal Collection, Elizabeth Bregg, "Providing Nursing Service for the Mentally Ill", *The Canadian Nurse* (Nov 1954):883-887.

62. Cyril Greenland, Jack Griffin and Brian Hoffman, "Psychiatry in Canada from 1951 to 2001", in *Psychiatry in Canada: 50 Years* ed. Q. Rae-Grant (Ottawa: CPA,

2001), 1-16.
63. Ibid.
64. Those early regional variations have had a lasting effect. About 10% of all psychiatric nurses in Ontario are male and in Western Canada, about 25% of all RPNs are male. Annette Osted, phone interview by writer, July 10, 2002. Osted noted that a generation ago more than 50% of RPNs were male. Also see Ruth Gallop, "Caring about the Client: The Role of Gender Empathy and Power in the Therapeutic Process" in *The Mental Health Nurse. Views of Practice and Education* ed. S. Tilley (Toronto: Copp Clark, 1997), 28-42. In her essay Gallop explained to British readers that British men played a more prominent role in psychiatric nursing than men in Ontario.
65. In Ontario attendants did not evolve into nurses. When I began this study I assumed (wrongly) that Ontario attendants transformed into nurses, and was corrected by several Ontario nurses and historians.
66. This high valuation of the male gender also played in the profession's early internal development. For instance, even though there were female psychiatric nurses, it was almost all men who served in executive positions in the Saskatchewan Psychiatric Nurses Association.
67. Grayce Sills, "In Memoriam, Hildegard E. Peplau, Nursing Scholar, Educator and Leader", *Journal of the American Psychiatric Nurses Association* (April 1999):41-43. As a nurse leader, Peplau had to deal with numerous obstacles. She was one of nursing's "elite" but life was hardly easy. See Barbara Callaway, *Hildegard Peplau: Psychiatric Nurse of the Century* (New York: Springer Publishing Co., 2002).
68. Of these nurses we know the least about Ogilvie, Bregg and Pullan.
69. WGH Alumnae Archives, Journal Collection, Dr. George Stevenson, "Ward Personnel in Mental Hospitals", *The Canadian Nurse* (Jan 1935):5-10.

Appendix A
Notice

This notice/advertisement will be placed in a variety of newspapers, newsletters and journals (national, provincial, local and professional associations) in Spring, 1999.

Psychiatric Nurses Wanted

For a dissertation I am researching on a history of psychiatric nursing in Canada, 1888-1950. I would appreciate having a chance to talk with psychiatric nurses who trained and/or worked/taught in Ontario, Manitoba or Saskatchewan provincial mental hospitals prior to 1950. The study involves an interview around personal recollections. Or perhaps you are able to share notebooks, diaries, journals, yearbooks, letters, scrapbooks or photographs? If you wish to be a participant &/or learn more about this project, please contact: Veryl Tipliski RN
, phone: ; fax:
email:

Appendix B
Interview Schedule

1. Could you tell me a little about your childhood/family background, for example, where did you grow up, your parents (working/middle), any cultural/ethnic influences?

2. How many, if any, of your relatives were nurses? Did this influence your choice to become a psychiatric nurse? If not, what did? Why that particular hospital?

3. What year was it when you first began training or working at the _____ Mental Hospital? How old were you? What was your first impression of the hospital?

4. Can you tell me something about the training you had at the hospital? What was student life like for you?

5. How would you describe the work you did at the hospital? What was everyday psychiatric nursing like for you? What things distinguished the work of the psychiatric nurse from that of others working at the hospital?

6. What can you recall about the medical treatments you were involved in?

7. What were the relationships between students and nurses; nurses and attendants; nurses and physicians; nurses and patients?

8. What stands out the most for you about your training? And the same for work? (positive or negative)

9. How did you perceive your psychiatric nursing training/work in comparison to general training and work? In your experience, what were the relationships between psychiatric and general nurses? Any issues that you were involved in?

10. What did you think of psychiatric nursing as a career?

Is there anything else that you'd like to add which we haven't discussed?

Appendix C
Follow Up Information Letter

Dear _____,

Further to our telephone discussion about my study of psychiatric nursing's Canadian history, here are all the details. The study is one of the requirements for a doctoral degree at the University of Manitoba. I am exploring the development of psychiatric nursing education and practice in Ontario, Manitoba, Saskatchewan, and possibly Nova Scotia, to 1950. As a part of this project, I would like to have the opportunity to interview nurses who trained/worked/taught at provincial psychiatric hospitals, about their experiences as students and nurses. The stories of nurses, combined with historical documents, creates a more balanced picture of nursing's past.

If you agree to participate, it will involve taking part in an interview which will last about 90 minutes. The interview will be tape recorded. Before the interview begins, you would choose one of two options. You can decide to use your full name in the interview, taping, transcripts, and the dissertation, or you can choose to keep your identity confidential. This would be done through the use of a pseudonym in the transcripts and dissertation. You would sign a consent form for one of these options. A copy of each form is enclosed for your information. In both cases, the information from the interview will be used in the dissertation and any publications around this study.

Since one of the purposes of this project is to record and recognize personal contributions to nursing history, it is hoped that the individuals who choose to be identified by name will also consider depositing their audiotape and transcript in the Provincial Archives of Manitoba. Therefore, when the tapes are completed, you may listen to your own and read the transcript, in order to help you make that decision. If you do decide to deposit you tape, you would sign a separate agreement with the Provincial Archives of Manitoba, which includes options for you to restrict access to any portions. If, following your review of the tape, you choose not to deposit the tape, the tape would be stored in the researcher's locked files for seven years, and then destroyed.

I am hopeful that you are willing to participate in this study. Participation is voluntary and you may decide an any time to discontinue the interview. I shall telephone you in one week. If you wish to discuss this project further, please call me at . Thank you for your consideration.

Sincerely,

Veryl Tipliski, RN,MN

Attachments

Appendix D
Consent to Participate in the Study of Canadian Psychiatric Nursing's History
CONSENT FORM

I, _____, have been asked by
Name of Interviewee
Veryl M. Tipliski, Graduate Student at The University of Manitoba, to talk about my past experiences as a student/nurse/instructor at a provincial psychiatric hospital.
I agree to be interviewed about my experiences. I understand that I can refuse to answer any questions and I understand that I can stop the interview at any time. The interview will last about 90 minutes. I agree to have the interview tape-recorded. The information will be used for this study and publication. I understand that there are no known risks to me. I may not benefit personally from this interview. I understand that I will be given an opportunity to listen to a copy of my tape and at this point, I will have two options from which to choose:

Option #1: I may elect to have the content of the tape recorded oral history remain confidential, in which case the tape and a transcript will be placed in the locked files of the researcher. Access to the transcript will be restricted to the researcher and her dissertation committee (Chair - Dr. A. Gregor, telephone (204) 474-8951). The information will be used for this study and publications, but my identity will not be revealed. Instead a pseudonym will be used.

Option #2: I may elect to have the content of the tape recorded oral history deposited in the oral history collection at the Provincial Archives of Manitoba so that future researchers may use the information. In this case, I will be able to choose certain restrictions, under a separate agreement with the Provincial Archives of Manitoba. The tape and transcript would be labeled with my name and other identifying information. My name would be used in any references to the interview appearing in the dissertation or publications based on the study.
I further understand that in the event that I do not choose Option #2 or do not return the completed agreement with the Provincial Archives of Manitoba for Option #2, the conditions outlined in Option #1 will apply, and all information on my oral history tape will remain confidential.

I have read the above description of the study and the researcher has answered my questions to my satisfaction. I voluntarily consent to participate in this interview.

_____ _____
Interviewee signature Date

To the best of my ability, I have explained the purposes, benefits, risks and inconveniences of this study, and I have answered all of the interviewee's questions.

_____ _____
Veryl M. Tipliski, RN,MN Date
Telephone (

Manitoba

APPENDIX E

Culture, Heritage and Recreation

Provincial Archives

200 Vaughan Street
Winnipeg, Manitoba, CANADA
R3C 1T5

AGREEMENT REGARDING ORAL HISTORY INTERVIEWS

I, _____ (INTERVIEWEE), HEREBY AGREE THAT THE ____ (NO.) TAPE RECORDING(S) CONDUCTED ON _____ (DATE) AT _____ (LOCATION) MAY, SUBJECT TO CANADIAN COPYRIGHT LAW, BECOME THE PROPERTY OF THE PROVINCIAL ARCHIVES OF MANITOBA AND, SUBJECT TO ANY RESTRICTIONS INITIALED BELOW, MAY BE USED UNDER GUIDELINES ESTABLISHED BY THE PROVINCIAL ARCHIVES.

I FURTHER AGREE THAT COPIES OF THE TAPE RECORDING(S) MAY BE GIVEN TO

_____ (NAME OF REPOSITORY) AND, SUBJECT TO THE SAME RESTRICTIONS, MAY BE USED UNDER GUIDELINES ESTABLISHED BY THAT INSTITUTION.

RESTRICTIONS: (Please initial)

None _____ or

1. The recording(s) is(are) closed to researchers for _____ years. During this period the recording(s) may be used only with my written permission._____

2. Other: _____

_____

I understand that any conditions initialed above apply during my lifetime only and that I will notify the Archives of any change to my address.

SIGNED: _____

ADDRESS: _____

_____

AGREED TO: INTERVIEWER: _____

DATE: _____

Appendix F

Outline of Affiliation Clinical Experience - Ontario Hospital, Hamilton

Clinical

- experience consists of a six week assignment in two of the clinical areas outlined below.
- an evaluation report is written by the Supervisor at the end of each six week period.
- the student submits a written evaluation. Both are evaluated by the Supervisor and student to aid the individual student in her future patient care.
- duties are changed every two weeks.

Similarities to all Wards

- have weekly discussions with the Instructor (10) the Supervisor (10 min. – 1 hr. daily and 1 hr. daily or weekly – varies with each ward) Chaplains (10) Social Worker (5).
- each student receives four weeks experience on medications and two weeks assisting with electro-convulsive therapy. They attend occupational therapy and recreational therapy activities for patients. They plan a group activity with patients twice during the course, with no direction from the Supervisor. They assist with meeting the direct and indirect physical and emotional needs of all patients and rehabilitation of post leucotomy patients. They attend conferences, teaching, intake, leucotomy and medical conferences (8). Patients are of all age groups and different types of behaviour.

Unit C, Ward 3

This is a female admission ward of 69 patients. The student participates in direct nursing care of approximately 10 patients in the observation dormitory and with the more indirect nursing care of ambulatory patients. She observes the psychiatric patient charting her observations and writing a daily psychiatric note. She assists with routine admission procedures (X-Ray, Lab. Dentist, GYN. Physicals, etc.)

Ward 9

This is a female refractory ward of 75 patients who display varying degrees of hyperactivity and chronicity but who respond to a program of occupational, recreational and industrial therapy. Here the student has an opportunity to use her initiative in establishing a good nurse-patient relationship. She also becomes acquainted with degrees of gross behaviour disturbances.

Unit G, Ward G-1

This is a female admission ward of 50 patients. Most are acutely ill. She observes the psychiatric patient, charting her observations of mental and physical symptoms and writing a daily psychiatric note on patients (10) in the observation dormitory. She participates in meeting the indirect needs of

ambulatory patients and the direct needs of bed patients. She also shares in the general ward duties. She assists with routine admission care.

Psychiatric Nursing Lectures

Unit I

Lecture 1 - Review of field of psychiatric nursing. History of the Ontario Hospital, Hamilton. Responsibility of the nurse on the psychiatric ward.
2 -The attitude of the nurse to the patient, the possible reactions of a patient on admission to hospital and methods of dealing with them.
3 - Observation of symptoms.
4 - Charting. This class is given as conference with small groups.
5 - Psychotherapy – methods. The nurse's part in psychotherapy.
6 - Shock therapy. Demonstration in the care of the patient having electro-shock treatment.

Unit II

Lecture 7 - nursing care of the depressed patient.
8 - nursing care of the excited patient.
9 - nursing care of the psychoneurotic patient.
10 - nursing care of the patient with special symptoms (negativistic, pre-occupied, impulsive, deteriorated).
11 - nursing care of the patient with organic psychoses.
12 - the nurse and occupational therapy
13 - personal adjustment.
14 - historical review.
15 - psychological tests and methods.
16 - the nutrition of the mentally ill.
17 - class period for questions and discussions.

Unit III

Hydrotherapy

Lecture 1 - history, methods.
2 - two hour demonstration and return demonstration of the continuous water bath.
3 - Two hour return demonstration of continuous water bath.
4 - Demonstration of cold wet pack and gavage feeding.