

“Never forget her sex:” Medicalizing Childbirth in Manitoba, 1880s to 1920s

by

Tamara Lee-Ann Miller

**A dissertation presented in partial fulfilment of the Doctorate of Philosophy,
Department of History, Faculty of Arts, University of Manitoba
Winnipeg, Manitoba
September, 2001**

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BY

Tamara Lee-Ann Miller

**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

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Abstract

This dissertation is a study of the ways in which childbirth was medicalized between the 1880s and 1920s through an intensive examination of the transformation of childbirth care in Manitoba. During these years, maternal and infant mortality and morbidity became public health concerns and the newly established professions of medicine and nursing aimed at both professional and social standing in Canada. The dissertation argues that the presence of physicians in the birthing room and, ultimately, the transition of the locus of childbirth from home to hospital, were neither accompanied by nor represented an immediate transfer of authority over the birth experience. As nurses and as patients, women were critical to the process of medicalizing childbirth. The dissertation is based upon patient records from Winnipeg hospitals and clinics, medical textbooks and journals, as well as information about medical and nursing education and practices, and demographic information about Winnipeg and Manitoba

Medicine offered the promise of safer, less painful births through the use of instruments and narcotics. However, these same remedies were often controversial within the profession and for patients. Physicians advocated their authority in the birthing room, but acknowledged their paucity of knowledge about the field of obstetrics. Nurses represented a new breed of medical professionals and struggled to forge a feminine professional identity alongside male physicians. Through their attendance at childbirth cases as scientifically trained caregivers, nurses gravitated between the two worlds of medicine and mothers. Patients, meanwhile, indirectly influenced the involvement of medical practitioners. By seeking or rejecting medical attendants, parturient women had a degree of control in the management of the birth process.

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Acknowledgments

I am, of course, eternally grateful for the financial support I have received along the way: the University of Manitoba, the Faculty of Graduate Studies, St. John's College, the University of Manitoba Graduate Students Association, and the John S. Ewart fund have been significant contributors. I am equally grateful to my colleagues and senior staff at the Department of Indian and Northern Affairs and the Department of Finance, who allowed me precious time away in order to complete this dissertation.

I am indebted to the staff at a variety of archives and records departments: the National Archives of Canada, the Provincial Archives of Manitoba, the City of Winnipeg Archives, the University of Manitoba Archives, the records departments of both the Health Sciences Center (Winnipeg) and the Grace Hospital (Winnipeg), and Neil John Maclean Health Sciences Library Rare Book Room, (Winnipeg). While most will not remember their individual contribution, it has been immeasurable.

Throughout my academic career, I have been fortunate enough to forge relationships with some extremely supportive academics. My thanks to Kathleen Jones, for leading me to the possibilities in history, to Barry Ferguson, for his advice and support, and to Mary Margaret Johnston-Miller, for her example. I would also like to extend a word of thanks to fellow students, faculty and staff at the Department of History, University of Manitoba.

All acknowledgments seem to end with a nod to friends and family, and so it is that I too close with a special reference to those who have watched, supported and listened, while I launched on this lengthy endeavour. Heartfelt acknowledgments are owed to my Mom, whose support and love have been constant; Dad, who taught me the meaning of personal and professional integrity; and my brothers, Brahm and Tristan, of whom I am continually proud. To friends - too many to mention - my endless thanks for your prodding and diversions. And to Kohji - for your loudly silent belief in me and for so much more.

Historian Harold Perkin wrote of his craft: "History is a profession of debtors, if not indeed of thieves, who shamelessly borrow or steal from one another, and who in fact could not trade upon their own capital."¹ This sentiment rings particularly true for graduate students labouring to grasp the arguments of their predecessors, while seeking to infuse the debate with original scholarship. In this dissertation, I have sought to build upon the arguments of my predecessors investigating historical developments in childbirth care. If, in some small way, I have contributed to the rich tapestry of social history, than I consider what follows to be a success.

¹ Harold Perkin, *The Rise of the Professional Society: England Since 1880*. London: Routledge, 1989, xv.

Introduction

The great events of an age, appear to those living through them, as backdrops only to the vastly more compelling dramas of their own lives.¹

Since I began this dissertation, the world around me has changed considerably. In the last year alone, I have witnessed the dawn of a new millennium and the birth of a new Canadian territory. Future historians will have to decide whether these events were truly 'historic' and redefining, or merely 'celebrated' in their time and historically incidental. Whichever category will apply, these events had a relatively minor impact on my daily existence. I have been far more engaged in and influenced by those ordinary milestones by which we map courses through our individual lives - obtaining employment, moving to a new city, starting a family. In truth, it has been the comparatively mundane activities of life that have had far more influence on me. These apparently apolitical and unhistorical events have shaped my personal history and my perception of the world around me.

It therefore seems appropriate to me that my topic - the childbirth experiences of some Canadian women between 1880s and 1920s - is mundane in comparison to the grand events of history. This subject-matter neither contributed to an overtly identifiable redefinition of the socio-political make-up of Canada, nor reshaped the geo-political map. Nonetheless, it constitutes a significant part of the Canadian historical experience. For understanding how individuals experienced the plainer happenings of day-to-day life provides a window into a private world, off-centre on the historical charts, but

¹ Guy Gavriel Kay, *Lord of Emperors*. Toronto: Viking, 2000, 312.

influencing the development of Canada as a nation, and significantly impacting on its citizens. Such common experiences of personal history coloured the way in which individual Canadians perceived the world around them, and affected how they reacted to that world. To assess comprehensively the development of Canadian society, this important stories must be told. The isolation and analysis in the historical record of the *Individual 'I'* represents an alternative and supplementary dimension to the isolation and analysis of the *Collective 'We'*, the latter representing the traditional focus of social history writing.²

At the turn of the twentieth century, Canadian society was redefining itself in a movement from an agrarian and rural-based economy to one rooted in urbanization and industrialism. Industrialization and rapid urban growth had created "an urban-industrial working class" and an "urban bourgeoisie".³ The social and political concerns of these different socio-economic groups conjoined in a reform movement which advocated moral and physical cleanliness. The 'bourgeoisie' fuelled a social purity movement constituting a "powerful if informal coalition for the moral regeneration of the state, civil society, the family and the individual."⁴ Simultaneously, from the newly-politicized working classes,

² For a discussion of the problems in identifying women's history within a collectivity, see Iris Marion Young, "Gender as Seriality: Thinking about Women as a Social Collective", *Signs*, 19: 3, 1994, 713-738.

³ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland and Stewart, 1991, 15.

⁴ Valverde, *The Age of Light, Soap, and Water*, 17.

emerged radical social reform rhetoric which publicly identified class disparities of privilege and income and brought to the forefront the plight of the poor.

The concerns of both working class and bourgeois groups were brought together in the organizations of yet a third group, "a middle group" comprised of neither radical labourers nor business leaders.⁵ This third educated group has been characterized as an intellectual community reacting to the social crisis of industrialization and urbanization in Canada and adapting social reform to the political agenda.⁶ Through this window, the domestic world, traditionally the realm of women, crept out from the private home to influence the political world of public affairs. This facilitated the development of an "increasingly important social domain that connected the public world of politics and the home."⁷ The result was that traditionally female topics - house keeping, childbirth, children - were acquiring a political identity. Through matters that touched on the domestic, a number of female organizations emerged to have a political impact on national discussions.⁸ A religious reform movement, the Social Gospel, lent additional rhetoric and a pulpit to the social reform cause. "There was an overlap in both personnel

⁵ Gerald Friesen, *The Canadian Prairies: A History*. Toronto: University of Toronto Press, 1993, 369.

⁶ Douglas Owsram, *The Government Generation: Canadian Intellectuals and the State, 1900-1945*. Toronto: University of Toronto Press, 1986, 29-49.

⁷ Gail Cuthbert Brandt, "Postmodern Patchwork: Some Recent Trends in the Writing of Women's History in Canada", *Canadian Historical Review*, LXXII: 4, 1991, 453.

⁸ See Wendy Mitchinson, "Early Women's Organizations and Social Reform: Prelude to the Welfare State," in Allan Moscovitch and Jim Albert, eds., *The "Benevolent" State: The Growth of Welfare in Canada*. Toronto: Garamond Press, 1987, 77-92.

and ideas between the social gospel and social purity."⁹ International influences from the United States and Britain contributed further flourish to a reform movement which increasingly adopted progressive terminology and agendas.¹⁰

The social agenda of the Canadian progressive movement included a purity campaign that fueled public health reforms and programs. Middle-class reformers, with the support of the still young Canadian medical and nursing professions, identified the filth and contamination of urban sprawl as a key contributor to disease.¹¹ Reformers scrutinized every aspect of the lives of all classes - diet, hygiene, behaviours. But their attentions were especially captivated by the working classes and the poor. The traditional assumptions about the distinctness of public and private spheres was challenged by reformers seeking to eradicate social ills. Openly contradicting Victorian notions of the home as a private sphere, reformers publicized the living conditions of the poor and took it upon themselves to enter homes and "cleanse" communities.

⁹ Valverde, *The Age of Light, Soap, and Water*, 18. For description of Anglican Church/Social Gospel involvement in the private issues of childbearing, see Angus McLaren and Arlene Tigar-McLaren. *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1980*. Toronto: McClelland and Stewart, 1990, 120.

¹⁰ For illustration of US influences, see Linda Kerber, "Separate Spheres, Female Worlds, Woman's Place: The Rhetoric of Women's History," *Journal of American History* 75, 1988, 9-39. For illustration of British influences, see Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1930*. Chicago: Chicago: University of Chicago Press, 1985.

¹¹ See Heather MacDougall, *Activists and Advocates: Toronto's Health Department, 1883-1983*. Toronto: Dundurn Press, 1990, 85.

Reformers used motherhood as one of the 'hooks' to advance their campaigns. High infant and maternal mortality rates catalyzed the social reformers' wide-open examination of private lives. Social reform organizations targeted women as mothers and potential mothers.¹² The mother image became a driving force behind the agendas of many reform organizations, even if this image completely contradicted the actual experience of working-class families.¹³

Women's issues could be found at the forefront of many of these social reform initiatives. Womanhood was adopting a new political persona in years surrounding the Great War. Emerging from a turbulent period, women had demonstrated their ability to support their families and country. While historians have argued that women's suffrage was a result of "political expediency"¹⁴, the fact remained that through having obtained the vote, women had obtained limited social and political roles rooted in their identities as mothers of the nation. In giving their sons to the war, women had earned recognition and social support from the nation for whom they had made enormous sacrifices.¹⁵ The result was that issues normally contained within the feminine community became part of

¹² For a brief discussion of the origins of maternalism, see Seth Koven and Sonya Michel, "Introduction: Mother Worlds," in *Mothers of a New World: Maternalist Politics and the Origins of the Welfare States*, Koven and Michel, eds. New York: Routledge, 1993, 10-19.

¹³ Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of the Welfare, 1890-1935*. New York: The Free Press, 1994, 55.

¹⁴ Robert Craig Brown and Ramsay Cook, *Canada 1896-1921: A Nation Transformed*. Toronto: McClelland and Stewart, 1974, 298.

¹⁵ Brown and Cook, *Canada, 1896-1921*, 298.

political debates and social reform discussions. Professional women, such as Dr. Helen McMurchy, director of the Maternal and Child Hygiene Division, were able to garner fairly prominent voices in certain issues perceived to be within the realm of the country's mothers.

What preoccupied many health reformers and women alike was the very real dangers of death and disability associated with childbirth. Thus, as the country faced a period of reconstruction, it was not surprising that attention should turn to the high price women paid in childbirth. As 'mothers of the land', reformers used socio-political pulpits to decry the fate of working-class women. Such organizations as the Women's Christian Temperance Union (WCTU) embarked on socio-political missions rooted in domesticity and religious gospel.¹⁶ Not surprisingly, some of the reform initiatives targeted childbirth as a primary cause of women's health problems.

Despite the developing political presence of women's issues in health care and social reform debates, the medicalization of childbirth was a gradual process, not instigated by hospitalization and the medical profession alone, but initially equally effected by women in the homes of patients. Historian Wendy Mitchinson has carefully explored the involvement of women in their medical treatment and, where sources permit, has demonstrated that women "did have a certain amount of power and they used it when

¹⁶ See Nancy M. Sheehan, 'Women Helping Women': The WCTU and the Foreign Population in the West, 1905-1930", *International Journal of Women's Studies* 6, 1983, 395-411.

they were able.”¹⁷ Her arguments are equally applicable to a more single issue focussed approach to women’s health care. As will be illustrated in the following chapters, women themselves were accomplices in introducing and effecting the involvement of medical practitioners in childbirth attendance during the first three decades of the twentieth century. Fears of high morbidity and mortality rates were prevalent, among professionals and patients alike, and the promise of safer, less painful births was alluring to both groups. Physicians saw a large potential market in obstetrics. Mothers saw a reprieve from the fear and desperation associated with giving birth. And nurses - gravitated between these two worlds of medicine and mothers - contributed to a mediated environment of maternal medical care.

However, while women encouraged, and in some cases demanded, the opportunities physicians made available for safer birthing, they did not necessarily see the need to relinquish control of their birth experiences. Despite the growing attendance of male physicians in the birthing room, the community of women, represented by mothers, midwives and nurses, remained a very strong presence and continued to have a hand in the management of the birth experience. The presence of physicians in the birthing room and, ultimately the transition of the locus of childbirth from home to hospital, were neither accompanied by nor represented an immediate transfer of authority over the birth experience. The latter occurred much more gradually as the result of an ongoing dialogue concerning the promise of science among traditional female care-givers and physicians.

¹⁷ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1991, 362.

“They [women] were not simply acted upon by the medical and government advisors,” writes historian Cynthia Comacchio, “but took part in the struggle to save their children, conserve their health, and modernize child rearing practices.”¹⁸

This is not an uncommon argument in the historiography of childbirth.¹⁹

Historians examining the decline of midwifery and the concurrent rise of obstetrics in Canada have drawn similar conclusions to those of American and British scholars concerning the birth experience of Canadian women. Historian Jo Oppenheimer, for example, in her study of childbirth in Ontario, has demonstrated how changes in birthing techniques were linked to a decline in maternal mortality rates.²⁰ Wendy Mitchinson, in her study of the relationship between Canadian women and their physicians in the Victorian era, has described the demands of women as co-operating with the professionalization of medicine and the shift to physician-attended births.²¹ Nanci

¹⁸ Cynthia R. Comacchio, *Nations Are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*. Montreal: McGill-Queen's University Press, 1993, 12.

¹⁹ See Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950*. New York: Oxford University Press, 1986; Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932*. New Brunswick, N.J.: Rutgers University Press, 1986; Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge, Mass.: Harvard University Press, 1995; Mitchinson, *The Nature of Their Bodies*, 1991.

²⁰ Jo Oppenheimer, “Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century”, in *Delivering Motherhood*, Arnup et al., 1990. See also, Veronica Strong-Boag and Kathryn McPherson, “The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939”, in *British Columbia Reconsidered: Essays on Women*, Veronica Strong-Boag and Gillian Creese, eds. Vancouver: Press Gang Publishers, 1992, 143-171.

²¹ Mitchinson, *The Nature of Their Bodies*, 164.

Langford argues that the isolation of prairie women led to greater use of alternative forms of birthing attendance.²² These arguments parallel those of American writers, such as Judith Walzer Leavitt, who have maintained that the wishes of women were in harmony with a more extensive medicalization of childbirth. However, other theories remain prevalent. Edward Shorter, in his historical study of women's bodies, focuses uniquely on the heroism of medical professionals as agents of progress, almost excluding female patients from the account.²³ At the other extreme, feminist scholars, such as Barbara Ehrenreich and Deirdre English, hold to the theory that the impetus for physician involvement in childbirth emanated primarily and exclusively from the medical profession.²⁴

While acknowledging that physicians had a hand in the medicalization of childbirth, medical professionals were not the sole actors. As historian Nanci Langford has shown in her analysis of birth on the Canadian prairies, "childbirth was a family affair, and every available adult, including hired men, had a role in the delivery."²⁵ My

²² Nanci Langford, "Childbirth on the Canadian Prairies, 1880-1930," *Journal of Historical Sociology*, 8, 3, 1995, 278-302.

²³ Edward Shorter, *A History of Women's Bodies*. New York: Basic, 1982.

²⁴ Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women*. New York: Doubleday, 1978; Ann Oakley, "Wisewoman and Medicine Man: Changes in the Management of Childbirth," in *The Rights and Wrongs of Women*, Ann Oakley and Juliet Mitchell, eds. New York: Penguin Books, 1976; Nancy Schrom Dye, "Modern Obstetrics and Working-Class Women: The New York Dispensary, 1890-1920," *Journal of Social History*, 20, 1987, 97-108.

²⁵ Nanci Langford, "Childbirth on the Canadian Prairies, 1880-1930," *Journal of Historical Sociology*, 8, 1995, 279.

study of childbirth in Winnipeg seeks to add the voices of women - mothers and female attendants - to the historical debate. As exemplified by Wertz and Wertz, the first generation of scholars studying childbirth based their analysis on the central perception that women were victims of patriarchal dominance.²⁶ More recently, historians such as Kathryn McPherson, have used the lense of female agency to analyse childbirth history.²⁷ The idea of female agency has two related connotations. The first, links specifically to the role of female-run organizations. More subtly, however, female agency also refers to the interpretive lense being used by feminist writers looking to tell women's history. They have highlighted the parts of the story that include women's involvement in shaping events in their lives, despite the omni-present influence of male professionals, and interpreted events in a light that includes female action and participation. For example, the use of narcotics is not perceived as a male authority overpowering a patient, but rather the result of patient demands. As historical sources ascribing direct voices to patients, especially women, are few, much of this study focuses on an analysis of the medical profession's understanding of, and reactions to, parturient patient demands. It also looks to the opinions of nursing attendants as predominantly women care-givers to provide a bridge to female voices on health care delivery.

²⁶ Richard W. Wertz, and Dorothy C. Wertz. *Lying-In: A History of Childbirth in America*. New Haven, Conn: Yale University Press, 1989

²⁷ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: Oxford University Press, 1996

Women may have been accessories in inviting physicians into the birthing chambers, but physicians did indeed have agendas of their own. At the turn of the century, medicine in Canada remained a fledgling profession, seeking to solidify standing for an upwardly mobile class. Doctors were part of an emerging professional class who were seeking to establish standing in society through the merits of their skill and training, rather than as a result of landed title.²⁸ Through their new relationships with mothers, physicians gained the authority, expertise, and clinical experience they had previously lacked. Many physicians relied on their newly established association with women to acquire the only adequate obstetrical training available to them. Poor and working-class women became part of the clinical training for student physicians, and were often the first patients subjected to new obstetrical techniques.²⁹ Indeed, physicians used their new role in childbirth cases to acquire distinction among health service providers. Claiming the authority of science, adherence to scientific technique, and superiority for their techniques over more traditional procedures, they gained socio-economic and political ground, sometimes at the considerable risk and expense of their patients.³⁰

While the presence in birthing rooms of a dominant and patriarchal medical profession is evident, exclusively attributing the medicalization of childbirth to the self-

²⁸ Harold Perkin, *The Rise of Professional Society: England since 1880*. New York: Routledge, 1989, 7

²⁹ Nancy Schrom Dye, "Modern Obstetrics and Working-Class Women," 550.

³⁰ Dorothy C. Wertz, "What Birth Has Done for Doctors: A Historical View", *Women and Health*, 8:1, 1983, 7-24.

aggrandizement of a single professional group is insufficient. Such a one-dimensional view marginalizes the role of women in the story. It cannot be disputed that physicians ultimately gained full control of birthing practices and effectively deposed the community of women. However, it would be a disservice to the historical process to ignore the prominence of women - as patients, as political proponents, and as medical professionals - in the medicalization of the childbirth experience. Women, those whose lives were most intensely affected by childbirth, were very much involved in their own treatment and care. They grappled with their own issues and concerns. In summoning medical professionals and the perceived expertise of science, they exerted and extended control over their own birth experience, with ironic consequences.

Medicine was unprepared for the exigencies of childbirth attendance. Simply put, late nineteenth and early twentieth century doctors knew little more, if not less, than traditional birth attendants about the physiology of birth. In a fifty year period following the introduction of physicians to the birthing room, treatment techniques and knowledge base changed very little. Nonetheless, physicians assumed an authoritative role, based predominately on patriarchy and the claims of science and professionalism. The balance between patient demands and professional knowledge was delicate. Though believing firmly that childbirth care was within their domain and purview, doctors remained unable to provide for the parturient woman any better service or treatment than the local midwife. And so, for a significant period of time, childbirth attendance remained in transition - no longer uniquely part of the traditional world of women, but not yet fully accepted within the hegemony of medicine. At the turn of the century, childbirth

experience straddled two very different though intimately related worlds. Male physicians required female collaboration in order to step from one world into the other. Some of that collaboration was provided by members of the nursing profession.

The predominately co-operative spirit of nursing professionals contributed to the realization of medical prerogative in childbirth. Nurses provided confinement care to poor and working class mothers. Historian Kathryn McPherson has shown that nurses occupied a unique role in the medical world, one simultaneously defined by class and gender.³¹ These scientifically educated female professionals shared cultural mores and socio-economic ties with the overwhelmingly male physician group. But their gender placed them in a different role from physicians at the bedsides of mothers. As a result, nurses were in subordinate positions to medical men, but were given the necessary tools to professionalize.³² Public health nurses, such as those from Winnipeg's Margaret Scott Nursing Mission, acted as a bridge between the traditional community of women who attended to confinement care and modern obstetrics.

Concentrating on Winnipeg, the scope of this study is clearly limited. But, it illustrates some experiences of Canadian women by focusing on a single Canadian city. In many ways, the demographic class structure and cultural constitution of Winnipeg provides a good cross-section of Canadian society. A nationally-recognized 'boom-town' at the turn of the century, Winnipeg was representative of a cosmopolitan Canadian

³¹ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: Oxford University Press, 1996, 9.

³² McPherson, *Bedside Matters*, 78.

centre. It felt the influences of both national and international trends in social reform and health care delivery. As with all case-study approaches, however, conclusions based on turn of the century Winnipeg are by nature constrained.³³ Specifically, this study is unable to extrapolate beyond the boundaries of Winnipeg and Manitoba to define conclusively the childbirth experiences at the turn of the century of Canadian women *in general*. Notwithstanding its limitations, this study can offer a rare glimpse into a still private world that was teetering on the edge of public consumption. The ingress of public health policy into the private homes of the nation was a trend which would continue throughout the remainder of the twentieth century. Looking back on Winnipeg at the beginning of the century offers a glimpse of a world which no longer exists - a world in which maternal and infant mortality were epidemic and a largely private and female concern, the roles and usefulness of physicians were limited, and the notion of state intervention in health care novel.

This dissertation is organized around a series of snapshots that illustrate childbirth experience in a specific urban environment. As with all histories, the content of this work has been shaped by available sources. In terms of identifiable source material, the topic of childbirth is doubly challenged. First, the history of women is a relatively recent phenomenon deriving a great deal of its methodology from feminist and social history approaches, and relying on the prevalence of non-traditional sources, such as oral

³³ For a synopsis of some of the current historiographical debates surrounding case studies see the Introduction of Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History*. Toronto: University of Toronto Press, 1998, 3-21.

histories, women's magazines, case records and personal letters. This study, too, relies on non-traditional source material, but I have tried to frame the story in a broader socio-political analysis. Throughout, I have been cognizant of Gertrude Himmelfarb's notion that "ordinary people . . . have been profoundly affected in the most ordinary aspects of their lives" by national events of significance.³⁴

A second challenge of the source material is attributable to the nature of medical documents. A treasure trove of material for the historian, medical chronicles, after a number of years, have minimal use in a discipline, such as medicine, which relies on scientific progress. They are outdated, and space is considered better spent on current literature.³⁵ Old medical texts or journals, the lifeblood of historical inquiry, are discarded in order to accommodate the latest material. Other historical jewels, such as individual patient records, are subject to privacy issues, and are often destroyed by hospitals as a matter of policy when a requisite period of time has passed. Those records that do survive are usually composed of forgotten piles of disorganized paper that chanced to escape the shredder or incinerator. Often sporadic and sketchy, they remain a valuable, if rare, historical source.

Such is the case for the patient registers unearthed for this study. They are incomplete, inconsistent in quality and sometimes disorganized, and do not represent

³⁴ Gertrude Himmelfarb, "AHR Forum: Some Reflections on the New History," *American Historical Review*, 94 (1989), 662.

³⁵ A further issue are the budgetary and space constraints that are leading archives to hang on to 'samplings', rather than complete record sets. See Iacovetta and Mitchinson, *On the Case*, 5.

complete sets of records. For the most part, they are standardized forms from sample years - some complete, some partially filled in - which provide limited background on the patient, a diagnosis, and perhaps a description of treatment. Even so, they have been subjected to some quantitative data analysis to meet the purposes of this study. The conclusions drawn from the records are inconclusive. Nonetheless, the records do provide an interesting, if limited, picture of the women who ventured to hospitals and nursing organizations for childbirth attendance.

The study begins by providing an overview and analysis of the political and professional environments in which women were giving birth at the turn of the century. The first chapter looks at the development of Winnipeg as an internationally recognized centre, ebbing and flowing with the national tide of events, and lays out the demographic character of the city. Through a brief analysis of national and international developments in public health care delivery, it depicts the environment within which physicians and mothers negotiated the contributions of modern medicine to childbirth care.

Chapters Two, Three and Four tackle an analysis of the medical model of parturient care derived from the medical professional literature. Chapter Two contains a brief history of the professional medical community in Canada and an examination of childbirth advice to physicians in the *Canadian Medical Association Journal*. It demonstrates that patients were unwittingly embroiled in the issues of a group of practitioners seeking professional status. Childbirth attendance, linked to a developing medical specialty, was part of a broader professional movement to eradicate non-licensed practitioners. Under the guise of professionalism, doctors were more willing than before

to enter the birth chambers of women, and provide a plethora of advice on childbearing and overall feminine health. Chapter Three documents the inclusion of childbirth care in the daily routine and culture of the medical institutional environment. It provides an interesting snapshot, through patient records from the Winnipeg General Hospital, of the women who attended hospital for childbirth. Chapter Four examines the expectations of physicians dealing with childbirth cases through an analysis of an educational curriculum and a study of some of the texts and publications used by physicians. The chapter discusses the obstetrical educational curriculum at the Winnipeg General Hospital, site of the Manitoba Medical School. This chapter analyses the medical texts used and the Manitoba Medical School's annual reports. It also provides a brief overview of more publicly distributed texts referred by physicians, the *Canadian Mothers' Book* and the *Pre-Natal Letters*. Together, Chapters Two, Three and Four seek to demonstrate the ongoing negotiations that were occurring between a medical profession seeking to further its own agenda, and a community of women seeking access to treatment during childbirth.

Chapters Five and Six bring the voices of nursing professionals into the world of childbirth care. While mothers and doctors were negotiating the role of medicine in the birthing chambers, nurses moved imperceptibly between both worlds. In so doing, they brought medical principles to the maternity bedside. Chapter Five reviews attitudes towards childbirth expressed in Canada's national nursing magazine between 1905 and 1930. The *Canadian Nurse* provides a picture of a professional group struggling to acquire legitimacy, while accommodating the social expectations of women at the turn of

the century. Nurses were weaving together notions of femininity and professionalism, merging professional training and beliefs with the remnants of traditional care-giving.

Chapter Six shows the operation of a national nursing perspective at the local level. It analyzes the childbirth attendance, including pre-natal and post-natal care, provided by the Margaret Scott Nursing Mission, a benevolent nursing organization operating in Winnipeg in the early 1900's. The records of the Mission demonstrate the dichotomy which developed when middle-class reformers involved themselves in the private lives of the working poor. Socio-cultural attitudes and prejudices, filtered through the lens of benevolence, impacted the childbearing experiences of those urban women dispossessed of traditional support circles and without means to acquire professional care.

The focus of this study is the medicalization of the childbirth experience. Notably absent are discussions of a myriad of issues associated with childbearing, including midwifery, birth control and child rearing, which undoubtedly coloured the experience for Canadian women.³⁶ My omissions of these topics, while regrettable, have been necessary to ensure the manageability of the project which focuses on the way in which women and physicians negotiated the medicalization of childbirth at the turn of the twentieth century.

³⁶ For example, Brian Burtch, *Trials of Labour: The Re-Emergence of Midwifery*. Montreal: McGill-Queen's University Press, 1994; McLaren and McLaren, *The Bedroom and the State*, 1989; and Sylvia Hoffert, *Private Matters: American Attitudes Toward Childbearing and Infant Nurture in the Urban North, 1800-1860*. Chicago: University of Illinois Press, 1989.

Chapter One

Public Health in Winnipeg, 1901 to 1921¹

In the late nineteenth and early twentieth centuries, the development of public health as a state supported initiative was developing into an international phenomenon. “Urban growth,” wrote historian Anthony S. Wohl, “created vast problems of sewerage and water supply, multiplied the risk of infection and contagious diseases, and increased awareness of the need to combat these challenges.”² In large metropolitan centres, social reformers allied themselves with physicians in order to meet the deadly challenges of the urban environment.³

As with many dynamic urban centres, the city of Winnipeg reflected national, and international, developments between 1901 and 1921. The country, claimed historians Robert Craig Brown and Ramsay Cook, was a nation in transformation, and the city of Winnipeg kept pace with that national character. The city followed global trends in economic and industrial development, and tackled the typical public health problems of a growing urban centre. In this burgeoning metropolitan centre, city officials confronted the same complications of rapid industrial and population growth as other large urban cities. Issues of public health - such as water supply, sanitation and the containment of

¹ The data making up the tables in this chapter have been drawn from the Government of Canada Census for 1901, 1911 and 1921.

² Anthony S. Wohl, *Endangered Lives: Public Health in Victorian Britain*. Cambridge, Mass.: Harvard University Press, 1983, 3.

³ For a discussion of the relationship between social reformers and physicians, see Elizabeth Fee and Dorothy Porter, "Public Health, Preventative Medicine and Professionalization: England and America in the Nineteenth Century," in *Medicine in Society: Historical Essays*, Andrew Wear, ed. New York: Cambridge University Press, 1992, 249-275.

disease - appeared paramount. Winnipeg, however, lagged behind in its public health endeavours. Though world medical pioneers were espousing the dangers of contagion, Winnipeg city council was reluctant to embark upon any major public health initiatives. It was in this medical culture that obstetrics began to emerge as a recognized medical specialty.

However, the character of Winnipeg, positioned as it was at the gateway to the Canadian west, created a unique environment that blended modern urbanization with frontier development. It is this atypical character that makes the city an interesting case study in public health development, especially with regard to maternity care. The contrasts which existed in the city - such as the traditions of immigrant communities juxtaposed against the modern hospital - provide for an analysis of public health issues which straddled two worlds. The character of the city provides for an analysis of childbirth attendance - itself poised between two worlds at the turn of the century - which incorporated the modern principles of public health with traditional beliefs and customs. With a booming immigrant population and the beginnings of an established middle class community, Winnipeg had the doctors and the mothers to create a birthing culture representative of the Canadian experience.

In the first two decades of the twentieth century, due in large part to immigration, the populations of both Canada and Manitoba increased dramatically. In Winnipeg alone, the number of inhabitants increased by over 300 per cent between 1891 and 1911. Part of the surge was attributable to the geographic settlement of the western territory. Population proliferation bolstered agricultural and natural resource production and gave rise to

foreign trade and investment. Maturation of a rail transportation network paralleled territorial and population expansion and opened up many previously inaccessible regions.⁴ As the gateway to Western Canada, Winnipeg felt the direct impact of these national developments. Its economy was infused with prospects and prospectors seeking to establish efficient access to resources and transportation networks. By the end of the nineteenth century, the city “assumed the role of the great metropolitan centre of western Canada, housing the leading educational, administrative, economic, and entertainment institutions of the region.”⁵ The city's hasty development was consistent with the demands of a nation in transition.

From earliest days, the city struggled with problems similar to those plaguing national law-makers and administrators. One such problem was a germinating public responsibility for health services and public health issues. In Canada, health issues were often left to languish as both dominion and local governments identified health matters to be the responsibility of the other. Municipal governments pointed to accountabilities of federal representatives. These, in turn, pressured provincial governments. While the *British North America Act* made pronouncements on the duty of the Dominion government with respect to quarantine, it also extended power to provincial governments for hospitals and asylums. The *Act* was ambiguous as to which level of government was

⁴ Robert Craig Brown and Ramsay Cook. *Canada, 1896-1921: A Nation Transformed*. Toronto: McClelland and Stewart, 1974, 1.

⁵ Artibise, Alan. *Winnipeg: A Social History of Urban Growth, 1874-1914*. Montreal: McGill-Queen's University Press, 1975, 74.

responsible for daily public health issues. As a result, public health endeavours only surfaced as a reaction to such severe crises as epidemics.⁶

Arriving in the city with few possessions and little capital, many immigrants settled in shanty-town-like environments. Entire communities were hastily built without benefit of sewage or water supply. They quickly became over-populated by the throngs of new arrivals.⁷ Public health advocates warned of the dangers posed by such unhygienic communities. For the most part, however, it was the threat of smallpox and typhoid epidemics which forced the involvement of local officials in public health initiatives.⁸

Once even a meagre public health program had been established, the infrastructure was in place for social reformers and the medical profession to marry their interests through the vehicle of health campaigns. One of the earliest such non-epidemic based health campaigns to emerge in Canada originated from the overseas recruitment problems during the Boer War (1899-1902). Many British recruits presenting for service were either physically or mentally unfit to serve their country.⁹ Great Britain's concerns about the poor quality of the soldiers, and the mothers who produced them, reverberated among

⁶ Jay Cassel, "Public Health in Canada," in *The History of Public Health and the Modern State*, Dorothy Porter, ed. Atlanta: Editions Rodopi, 1994, 280.

⁷ Artibise, *Winnipeg: A Social History*, 179-182.

⁸ Artibise, *Winnipeg: A Social History*, 223.

⁹ Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*. Toronto: McClelland and Stewart, 1990, 92.

Canadian public health reformers.¹⁰ Concerns over the unhealthy state of the Canadian population translated into health campaigns focussed on high infant mortality and disability rates which inevitably targeted mothers and highlighted the need for maternity care.

Though Winnipeg's growth was propelled by settlement and immigration in the late 1800's, the area had previously been settled by Aboriginal and early European migrants. The territory at the junction of the Red and Assiniboine Rivers had been a long-time meeting place for trappers and traders participating in the fur trade. It had not been settled for agricultural purposes until 1812 with the arrival of thirty-six Irish and Scottish labourers.¹¹ At that time, the Red River colony was under the monopoly of the Hudson's Bay Company (HBC) and had attracted few agricultural settlers since the HBC was opposed to any type of occupation which might have interrupted the lucrative exchange of furs. Nonetheless, a small community established itself, drawing on its own population of industrious migrants and Métis.¹²

By the 1860s, the Red River settlement had established a trading network with its

¹⁰ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland and Stewart, 1991, 20.

¹¹ Artibise, *Winnipeg: An Illustrated History*. Toronto: James Lorimer and Co., 1977, 11. The first settlers came at the behest of Lord Selkirk, a philanthropist who had acquired 120,000 square miles of land from the Hudson's Bay Company.

¹² The Métis were the children of French white traders and native mothers who had established family networks and communities prior to the arrival of the Selkirk settlers. See John E. Foster, "The Origins of the Mixed Bloods in the Canadian West", in *Essays on Western History*, Lewis H. Thomas, ed. Edmonton: University of Alberta Press, 1977, 71-80; 202-205.

southern neighbours in St. Paul, Minnesota. Moving into the second half of the century, fur trade settlements became more permanent communities as the HBC began to loosen its grasp on settlement in the area. Overall, however, despite modest increases in population, the Red River settlement remained a small agricultural community, barely discernible on a map of the Northwest Territories.

It was not until Manitoba entered Confederation in 1870, that central Canada looked to Winnipeg as a seat of activity in the Western territories. Real estate speculation spurred the economy which in turn drew settlers to the area.¹³ An *Act of Incorporation* in 1873 created the City of Winnipeg, complete with a civic council and by-laws. However, the most powerful contribution to the growth of this prairie city did not come about until 1881 with the decision of the Canadian National Railway to run a line through Winnipeg instead of the nearby community of Selkirk.¹⁴ In 1881-82, Winnipeg experienced a land boom that drove real estate prices to unprecedented heights and led to a remarkable amount of construction. Unwittingly, yet strategically, positioned at the centre of the North American continent, the City of Winnipeg quickly grew into a major railway interchange point. The rail lines fed an industrial frenzy as business sought to capitalize on the growth potential of the young city and established manufacturing centres at the

¹³ For a discussion of the real estate boom and its effects on the growth of Winnipeg, see Artibise, *Winnipeg: A Social History*, 1975, chapters 2 & 3.

¹⁴ For a discussion of the importance of railways to the development of prairie towns, see Paul Voisey, "The Urbanization of the Canadian Prairies, 1871-1916," *Histoire Sociale/Social History*, VII, 1975, 77-101.

"gateway to the west."¹⁵ The manufacturing fever drew a multitude of migrants looking for employment and opportunity in a city that did not deliver services that paced population growth. As one contemporary noted:

The fact is that Winnipeg in her feverish desire to grow, only to grow, was not in the least concerned to grow properly and healthfully, to develop sanely. Her mad passion for evidences of her expansion, her insistent demand for figures to prove growth, and only growth, be it by building permits, or by bank clearances, or by customer receipts, or by pavement mileage, or preadventure by the price of vacant land, any process of growth demonstrating, have blinded her to the fact that cities cannot live by growth alone.¹⁶

People and money poured into the prairie city. Winnipeg swelled to accommodate the surge.

Accompanying the dramatic growth of the city was a burgeoning business elite. As early as 1879, city businessmen had established a Board of Trade to promote investment in city resources and to forge a network of business relations.¹⁷ By 1887, the Grain and Produce Exchange had opened in the basement of City Hall, making Winnipeg a central point for agricultural trade in Canada. The decision to accord favourable freight rates to Winnipeg merchants heightened the city's competitive advantage over other Western cities.¹⁸ Agricultural trade spawned a myriad of business endeavours including banking, insurance and wholesaling, as merchants and industrialists looked to establish

¹⁵ "Highlight Tour" given at the Manitoba Museum, 1993-1995.

¹⁶ Cited in Artibise, *Winnipeg: An Illustrated History*, 30.

¹⁷ For a discussion of the involvement of the Board of Trade in governmental policy see Artibise, *Winnipeg: A Social History*, 46-50.

¹⁸ In 1886, the Winnipeg Board of Trade successfully negotiated a 15% discount on goods shipped west by local companies. In 1890, the same preferential rate was accorded to incoming goods. Artibise, *Winnipeg: An Illustrated History*, 32.

themselves in the prosperous economy. By the turn of the century, Winnipeg had grown into a cosmopolitan municipality and was seen as a bright spot on the Canadian prairies. However, bright lights that burn too brightly often burn themselves out. Winnipeg was no exception.

Despite the predictions of optimistic forecasters, urban growth began to stagnate in the second decade of the twentieth century. As a result, Winnipeg suffered from the ill-effects of over-speculation. Real estate prices fell; industrial development slowed. The growth of urban centres on the Canadian prairies depended heavily on expanded settlement, and the production of agricultural communities. But by the early 1900s, almost all the arable territory in Manitoba had been cultivated. In order to harvest natural resources, farmers required cities and towns to provide services, supplies and transportation. When rural settlement slowed, urban expansion became unnecessary.¹⁹ With the opening of the Panama Canal in 1914, international grain transport routes were altered as ocean passage became manageable and affordable for Canadian and European merchants. Rail transportation was by-passed in favour of sea passage.²⁰ Domestically, preferential freight rates, a long-time issue on the Western Prairies, were abolished. Other Western cities were now equally competitive with Winnipeg in the transportation market. The Pacific port city of Vancouver, and other burgeoning towns, such as Edmonton, Calgary and Regina, challenged Winnipeg's dominance over Western Canadian trade.

The outbreak of World War I directly impacted Winnipeg's economic

¹⁹ Voisey, "The Urbanization of the Canadian Prairies, 1871-1916," 383-407.

²⁰ Artibise, *Winnipeg: An Illustrated History*, 116.

environment. War production and the demand for grain overseas infused the local economy. However, it also meant a labour shortage as able men enlisted and were sent overseas. The war boom and the call to military service increased the demand for labour, but also constrained any corresponding improvement in wages.²¹ In addition, the effects of rapid growth lingered in the sweat shops and industrial floors of the city where working conditions were unregulated and often abusive. As the war drew closer to its end, the loathsome labour circumstances combined with the demands of returning veterans catalyzed labour activists to petition for protective labour legislation. During the 1910's, Winnipeg endured a series of labour strikes which culminated in the General Strike of 1919. All of this served to limit Winnipeg's uncontrolled industrial and manufacturing expansion.²²

The state of the economy closely affected population surges and consequent geographic development within prairie communities. Upon its incorporation in 1873, a little over 200 people resided in Winnipeg. The focal point of the community was Main Road, which had served as the trade route linking the Hudson's Bay Company posts at Upper Fort Garry and Selkirk. Notre Dame Street, intersecting Main and leading to St. Boniface, was intended to be the second major route through the city. In the result, all new construction had emerged around this key intersection.²³ With the economic boom

²¹ Artibise, *Winnipeg: An Illustrated History*, 110.

²² Winnipeg had its first Labour Party in 1895. In 1906, workers from the Winnipeg Electric Railway Company went on strike. For a full discussion of the Winnipeg General Strike see David Bercuson, *Confrontation at Winnipeg: Labour, Industrial Relations and the General Strike*. Montreal: McGill-Queen's University Press, 1990.

²³ Artibise, *Winnipeg: A Social History*, 148. Today, this intersection is recognized as the corner of Portage Avenue and Main Street.

of 1881-82, civic officials sought to establish a plan for the growth and development of the city. They adopted a ward system, dividing the city into six distinct sections. However, despite ward boundaries, the city developed as three identifiable districts - the Central Core, the North End and the West and South Ends - outlined by formal geographic boundaries (see Map I). The districts were also characterized by the socio-economic classes of the inhabitants: "In general, Winnipeg's spatial growth was marked by a core of middle and working-class elements, surrounded on the south by the middle class, and on the north by the working and lower class."²⁴

The Central Core developed around the original intersection of Main and Notre Dame as the administrative and business district of the city. Initially residential, by the turn of the century the area was dominated by light industry (i.e., textiles, printing), commerce, government, and the omnipresent grain exchange.²⁵ Composed of Wards 2 and 4, the district blended working-class industrial labourers and middle-class retail and government employees.

The North End, enclosing Wards 5, 6 and 7, developed into the working-class and immigrant quarter of the city. The dominant feature of the area was the Canadian Pacific Railway yards, which cut through the heart of the district, acting as an iron boundary between the North End and the Central Core. The filth and noise emanating from the yards dominated the district whose residents were often employed by the rail company. Most of the city's heavy industry was located in proximity to the rail facilities, further shaping the character of the district. Proximity to employment opportunities and cheap

²⁴ Artibise, *Winnipeg: A Social History*, 157.

²⁵ See Artibise, *Winnipeg: An Illustrated History*, 58-64.

properties meant that the North End drew many of the new arrivals to the city. Dubbed the "foreign quarter", the North End wards suffered from unsanitary conditions, lack of proper sewage systems and chronic overcrowding. Initially attractive to immigrants because it provided affordable accommodation, the North End, by the early 1900's, drew its immigrants because of the ethnic community networks previously developed by earlier arrivals.²⁶

Wards 1 and 3, the south and west ends of the city, housed the middle and upper-classes. These districts did not really develop until after 1900, due to the absence of adequate transportation for commuting. The Canadian Northern Railway yards were located in a corner of Ward 1. Otherwise, little commercial or industrial development arose in this area. Civic planners made a conscious effort to develop the locality's residential character by allocating large dwelling lots and plenty of green space for parks. As a result, home prices in the district exceeded working-class finances.²⁷

At the outbreak of World War I, almost one-third of the population of the Canadian prairies lived in urban centres such as Winnipeg.²⁸ Winnipeg²⁹ was rated the sixty-second largest city in Canada upon its incorporation in 1873.³⁰ By 1921, however, Winnipeg ranked third in the country with a population greater than 179,000 and

²⁶ Artibise, *Winnipeg: A Social History*, 158-165.

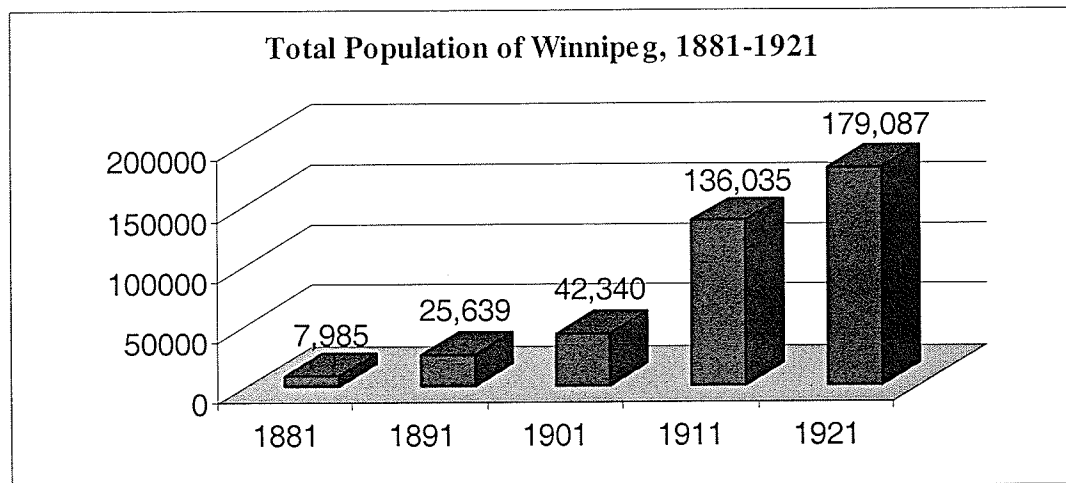
²⁷ Artibise, *Winnipeg: An Illustrated History*, 68-74.

²⁸ Voisey, "The Urbanization of the Canadian Prairies," 383.

²⁹ For the purposes of this study, the City of Winnipeg includes only the seven wards described above.

³⁰ Based on numbers available from the Census of Canada for 1901, 1911 and 1921, and from Artibise, *Winnipeg: A Social History*, 130 & 132.

Chart I



Source: Government of Canada Census, 1901, 1911, 1921.

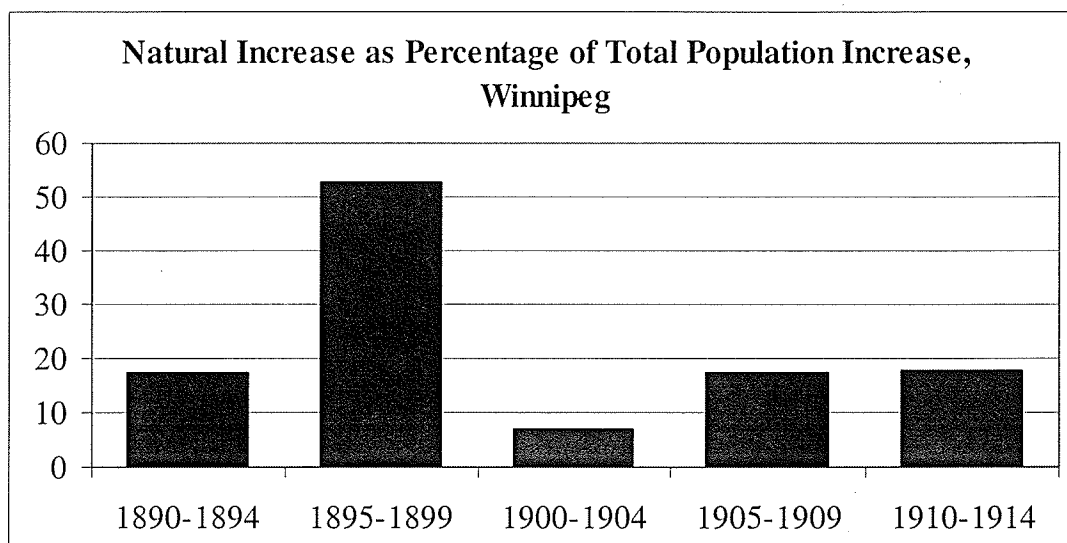
During this significant decade, the population expanded by three hundred and twenty percent.

Population growth was attributable to three discernible factors - territorial annexation, natural increase and immigration. However, the three elements were not equally contributory. Between 1873 and 1913, territorial expansion accounted for the city's inclusion of approximately 3,500 inhabitants. Territorial limits expanded significantly to the north, west and south, but much of the annexed property was uninhabited (see Map II).³¹

The second factor, natural increase, defined demographically as the number of births over the number of deaths in a given territory, played a greater role in population expansion. Natural increase was especially significant between 1895 and 1900, when over 50% of new inhabitants were attributable to births within the city (see Chart II).

³¹ Artibise, *Winnipeg: A Social History*, 136.

Chart II



Source: Government of Canada Census, 1901, 1911, 1921.

However, neither natural increase nor territorial annexation accounted for very much of the population growth overall. For example, natural increase, except during its 1895-1899 peak, consistently accounted for less than 20% of total population increase.

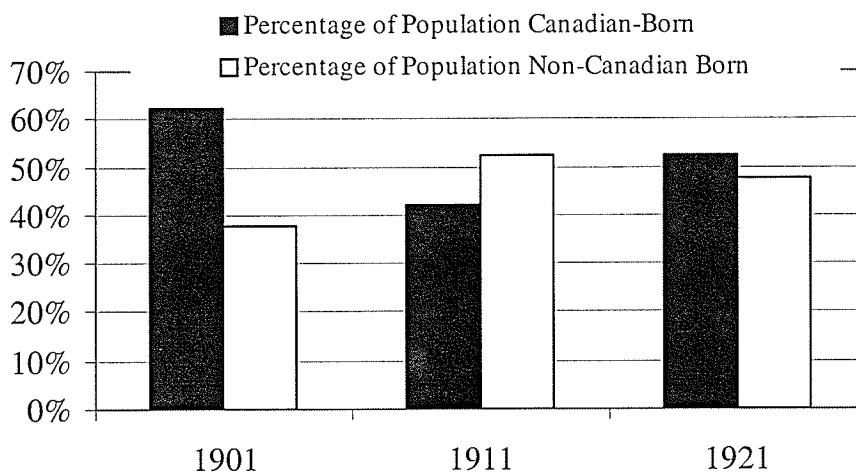
The remaining and most important source of population expansion was the arrival of new immigrants. In order to solidify the western territory, Canada's federal government openly encouraged immigrant settlement. An aggressive recruitment campaign, led by the Minister of the Interior, Clifford Sifton (1897-1905), supported federal immigration policy.³² Accordingly, Winnipeg, "gateway to the west", received thousands of new immigrants every year. Chart III illustrates that, in 1901, non-Canadian born Winnipeggers represented nearly 40% of the city's population; however, by 1911, more than 55% of Winnipeg residents had been born outside Canada. This immigration surge between

³² See Gerald Friesen, *The Canadian Prairies: A History*. Toronto: University of Toronto Press, 1993, 245-46.

between 1901 and 1911 coincided with Winnipeg's dramatic overall population increase. Following its peak, immigration decelerated during the 1920s. By 1921, the Canadian-born population had regained numerical prominence, although a large proportion of Canadian-born residents were the second-generation children of immigrant families.

Chart III

Birthplace of Winnipeg Population, 1901, 1911, 1921



Source: Government of Canada Census, 1901, 1911, 1921.

Economic factors influenced the curtailing of immigration to the city. These included an unfavourable shift in trading conditions (the Panama Canal opened in 1914) and the rise of other Western cities. Together, these factors diminished Winnipeg's competitive market advantages.³³

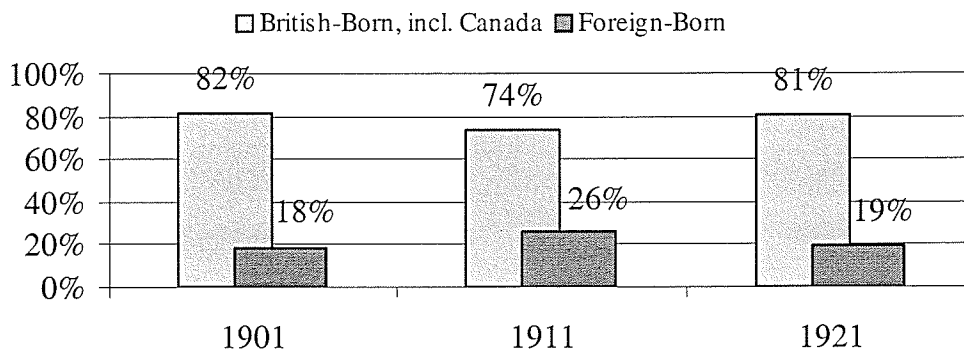
Despite high numbers of immigrants, the city's dominant character remained British. Data presented in Chart IV affirms that a high proportion of Winnipeg residents were either born in Britain or a British territory, including Canada. In 1901, this included 81.9% of

³³ Artibise, *Winnipeg: An Illustrated History*, 116.

Winnipeg's population (only 18% had been born elsewhere). By 1911, at the tail of the immigration surge, the city's foreign-born had increased to 24%, however, the British-born still had an enormous numerical advantage. 75.8% of the city's population, three out of every four persons, had been born in Britain or a British territory. Winnipeg's population was undoubtedly British.

Chart IV

Birthplace of Winnipeg Population: 1901, 1911, 1921



Source: Government of Canada Census, 1901, 1911, 1921.

British predominance aside, those of non-British birth still made up a significant enough proportion of the population to attract attention. The presence of non-British-born immigrant communities was relatively novel to the new world, and was affecting the entire country. "They [immigrants of non-British origin] were too numerous to be rapidly absorbed into a Canadian melting pot," note historians Robert Craig Brown and Ramsay Cook, "They did not simply reinforce old Canada. Indeed, they often challenged it."³⁴

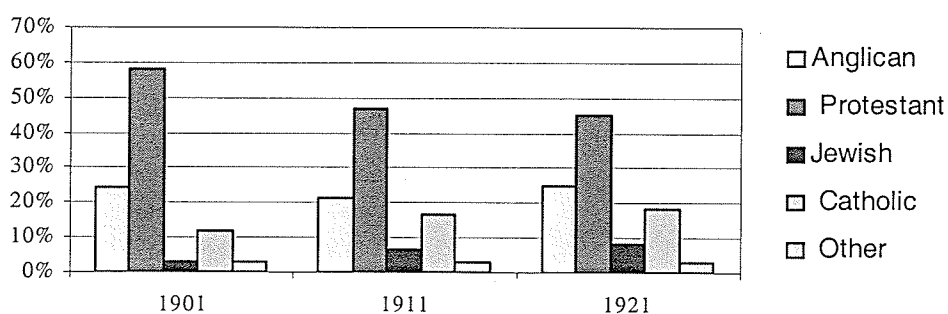
Consistent with the city's British cultural character, denominational data reveal that

³⁴ Brown and Cook, *A Nation Transformed*, 1.

the dominant religion in Winnipeg from 1900 to 1920 was Protestantism. Chart V details religious denominational adherence between 1901-1921. During this period between 45% and 57% of Winnipeggers were listed as Protestant; another 20% to 25% affirmed the Anglican faith.

Chart V

**Religious Denominational Percentages for Winnipeg:
1901, 1911, 1921**



Source: Government of Canada Census, 1901, 1911, 1921.

Despite Anglo-Protestant predominance, however, the city manifested an extending multi-denominational mosaic. The 1911 and 1921 figures show a definite increase in the denominational proportions of Jewish and Catholic residents in the city.

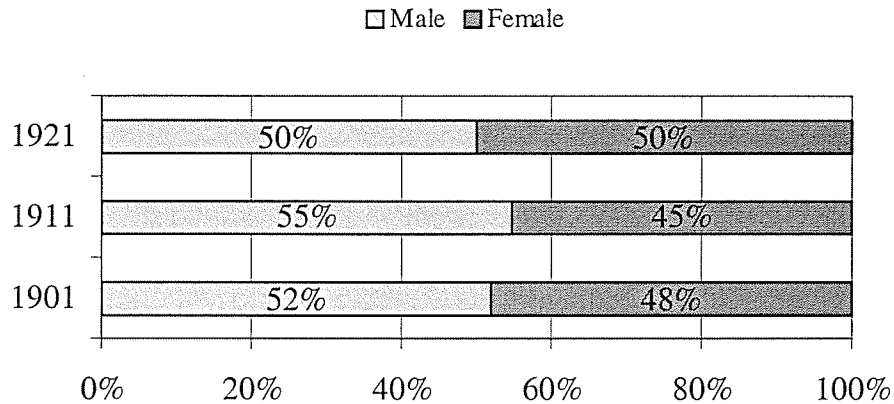
The dominant British cultural flavour of the city, while at no threat to be overwhelmed by multi-cultural invasion, was significantly spiced with multi-cultural and multi-denominational seasoning. Large, non-homogeneous, immigrant groups were unfamiliar in the Canadian landscape; their presence in Winnipeg, specifically, and Western Canada, generally, coloured much of development of the Canadian West.

The proportion of men to women in Winnipeg remained more-or-less consistent between 1901 and 1921, with a minor surge in male inhabitants in 1911, co-incident with

the surge of immigration between 1901 and 1911.

Chart VI

**Gender Distribution of Winnipeg Population:
1901, 1911, 1921**



Source: Government of Canada Census, 1901, 1911, 1921.

Chart VI reveals that the male population of the city reached close to 55% in 1911 before levelling off by 1921, when the proportion of male to female was about equal.

The higher male percentages are attributable to migrants and immigrant seeking employment. Throughout this boom period, the city was home to a large number of migrant workers who looked to the city as a stationary point between jobs. Immigrants seeking employment were often male. Once employed, many of these would settle down, either by marrying in Canada and starting families, or by bringing their families in the 'old country' to Canada.

Though home to a transient population seeking to find fortune in points west, nonetheless, Winnipeg's gender proportions represent those of a relatively stable population. Unlike many settlement towns built on the exploitation of a single resource, where the number of men far exceeded the number of women, Winnipeg's gender proportions

proportions remained reasonably balanced indicating a tendency towards the establishment of a permanent community.

Demographically, Winnipeg evolved similarly to other prairie towns in the first two decades of the twentieth century. Immigration influxes and a burgeoning economy contributed to fast-paced growth, dominated by the presence of British-born immigrants. With trade networks stretching to the east, south and west, Winnipeg was influenced by the same broad social and economic trends that affected the continent at large.

At this time, Winnipeg also began to confront many of the problems with which older and larger cities had been grappling since the industrial revolution - overcrowding, poor sanitation, and the containment of disease. Concepts of public health emerged to infiltrate the ideologies of city planners and officials seeking to manage the problems associated with a larger and more rapidly growing population. In the period between 1890 and 1930, public health materialized as one of the most significant developments in medicine and health care. Driven by Victorian values, the ideology of public health reform involved the isolation of contaminants in a bid to eradicate the perceived etiologies of ill-health. Public health became a social movement modelled after developments in the science of bacteriology, which had successfully identified some microbial causes of disease. Its most significant impact, however, was to remove health issues from the privacy of home, and establish a public forum for communal responses to health threats. Questions of disease, traditionally the territory of the individual sufferer, became a matter for the public domain and a responsibility of the state.

The roots of public health ideology can be traced to the Greco-Roman period; early

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The roots of public health ideology can be traced to the Greco-Roman period; early city-states established water supply and drainage systems, bath houses, and

contended with epidemics. These initiatives represent the rudimentary origins of public health in the western world.³⁵ More modern public health theory began with the work of English lawyer and health reformer, Edwin Chadwick (1800-1890). Emerging from his engagement with Britain's Poor Law Commission in the 1830's, Chadwick focussed his career on isolating the causes for ill-health among the labouring poor. He summarized his conclusions in 1842 in a monumental publication entitled *The Sanitary Condition of the Labouring Population of Great Britain*. The enormous influence of Chadwick's work led to the acceptance of two fundamental principles in public health theory: firstly, poverty and filth were direct determinants of poor health conditions; and secondly, government needed to accept some form of responsibility for the health of its working-class citizens.³⁶ The result was the Public Health Act of 1848. The Act encouraged a network of local health boards administrated by a central General Board of Health. Under direction of a Medical Officer of Health (MOH), local boards were given "[a]uthority . . . to deal with water supply, sewerage, control of the offensive trades, provision and regulation of cemeteries, and a number of other matters."³⁷ Accordingly, control of disease fell under government jurisdiction, and developed into its own medical science.³⁸

³⁵ George Rosen, *A History of Public Health*. New York: MD Publications, Inc., 1958, 30-50.

³⁶ C. Fraser Brockington, "The History of Public Health," in W. Hobson, ed., *The Theory and Practice of Public Health*. Toronto: Oxford University Press, 1979, 4; Edwin Chadwick, (1842), *Report on the Sanitary Condition of the Labouring Population of Great Britain*. Edinburgh: Edinburgh University Press, 1965.

³⁷ Rosen, *History of Public Health*, 221.

³⁸ The science and practice of public health has developed quite independently of organized medicine in most western societies; e.g. public health training and education in the United States, for example, has been organized around 'schools of public health',

The increasingly expanding profile of public health was spurred and supported by the science of bacteriology and the isolation of microbiologic causal agents in the spread of disease. The French chemist Louis Pasteur (1822-1895) debunked the myth of the spontaneous generation of bacteria by demonstrating the theory of contamination. Working in the same period, the German physician Robert Koch (1843-1910) isolated specific bacilli for anthrax, tuberculosis, cholera and sleeping disease.³⁹ By the late 1900's, bacteriology could trace the pathways of contagion and show the mechanism of infectious disease: Identifiable organisms (bacteria) infected the sufferer, producing symptoms of illness characteristic for that organism. According to the theory, if bacteria could be identified, and irradiated, the mechanism of contagious transmission could be interrupted and the illness could be prevented. Armed with the ebullient promise of the new science, public health reformers were persuasive.

Although slightly before the discovery of bacteriology, Edwin Chadwick outlined an unprecedented public health policy for Britain. "Chadwick's public health was, to some extent, an expression of the political philosophy of his country, a distrust of autocratic rule; but it was also a child of the Industrial Revolution, which by the second quarter of the nineteenth century had given rise to remarkable changes in both the

administratively independent from medical colleges. However, in Canada and the United Kingdom, there has been less of a separation. In recent years, the medical sub-specialty known as community medicine has arisen in the latter two countries to encompass traditional public health content.

³⁹ Rosen, *A History of Public Health*, 512. See also Terry Copp, "Public Health in Montreal, 1870-1930," in S.E.D. Shortt, ed., *Medicine in Canadian Society: Historical Perspectives*. Montreal: McGill-Queen's University Press, 1981, 396.

environment and the demography of a small island.”⁴⁰ Central to Chadwick’s revolutionary doctrine was the assumption of mutual causation between poverty and disease - not just was poverty a cause of disease, but also, disease was a cause of poverty. His public health emphasized the environmental, rather than the personal, determinants of health. It followed that government, rather than individuals, carried the responsibility for hygiene with its salutary effects on the health of the population. It was necessary for... administrators and doctors to become aware of the need for public measures of control and their effectiveness.⁴¹ Canadians built their public health structures on very similar models, with local and provincial boards of health as the administrators of public health initiatives.⁴²

By the late nineteenth century, suggest Canadian medical historians, “Manitoba looked like a Third World country of today, with regular flooding, foul water, poor sanitation, poor housing, inadequate and dirty food, and rampant infectious disease. Tuberculosis and venereal diseases were endemic, and typhoid, dyptheria, and scarlet fever, recurrent.”⁴³ The impetus for a coordinated response to public health threats, however, was the discovery of a smallpox epidemic among the Icelandic population in the interlake region in 1876. At the request of the provincial government, Manitoba physicians mobilized and the community was kept under strict quarantine. The measures

⁴⁰ Brockington, "The History of Public Health," 4.

⁴¹ Brockington, "The History of Public Health," 4.

⁴² Neil Sutherland, "‘To Create a Strong and Healthy Race’: School Children in the Public Health Movement, 1880-1914," in Shortt, *Medicine in Canadian Society*, 363.

⁴³ Ian Carr and Robert E. Beamish, *Manitoba Medicine: A Brief History*. Winnipeg: The University of Manitoba Press, 1999, 24.

were effective and the disease was contained. The community, however, was devastated.⁴⁴ A report by Winnipeg's Medical Health Officer, J. Kerr, emphasized the need for quarantine and inspection procedures for all immigrants.⁴⁵ However, no concrete measures had been adopted to inspect migrants for communicable diseases, even after the opening of rail connections from the East in 1885. Part of the inactivity can be attributed to the perception that the health inspection of immigrants was a federal responsibility.⁴⁶ As a reaction to the threat, the provincial government established a Provincial Board of Health reporting to the Minister of Health, (who also happened to be the Minister of Agriculture and Immigration) which included a bacteriologist.

Over the course of the next few decades, public health theories germinating overseas in Britain and Europe established recognizable roots in Manitoba. Revisions to the *Public Health Act* in 1911 incorporated food, milk, water and sewage inspection under the provincial medical board's jurisdiction. In 1916, the Provincial Bacteriologist was added to the Board and one of its members was appointed Chief Officer of Health for the province.⁴⁷ Also that year, the province hired five public health nurses, a forerunner of the Provincial Public Health Nursing Service established in 1917. In 1928, the

⁴⁴ Carr and Beamish, *Manitoba Medicine*, 24-25.

⁴⁵ Artibise, *Winnipeg: A Social History*, 185.

⁴⁶ Artibise, *Winnipeg: A Social History*, 185. For a discussion of the continuing conflict between local and national governments with respect to responsibility for epidemics, and its disastrous consequences, see Jim Daschuk, "The Keewatin Smallpox Epidemic: A Study in Administrative Failure". Unpublished paper, History 729, University of Manitoba, 1992.

⁴⁷ Ross Mitchell, *Medicine in Manitoba: The Story of Its Beginnings*. Winnipeg: Stovel-Advocate Press, Ltd., 1954, 70. Carr and Beamish, *Manitoba Medicine*, 61.

Ministry of Health and Welfare assumed all responsibility for health-related matters.⁴⁸

The medical profession itself was taking root in the provinces through the establishment of medical institutions and professional organization. Coincident with state acceptance of a role in public health, the *Provincial Medical Health Board of Manitoba* was constituted in 1870 to register medical professionals in the province and control their licensure. Also in 1870, the Grey Nuns founded the St. Boniface Hospital, and by 1875, the Winnipeg General Hospital was in full operation.

With the formation of the College of Physicians and Surgeons of Manitoba in 1877, under the presidency of James Lynch (an attending physician at the Winnipeg General), physicians gained firm control over the professionalization of medicine in Manitoba.⁴⁹ The Winnipeg circumstances replicated those for the medical profession in other large North American cities. The Manitoba Medical School, first of its kind in Western Canada, was established in 1882 with lectures provided by the attending staff at the Winnipeg General Hospital, and residents seeking appointments. Within the burgeoning medical profession, maternity and obstetrical care were also being taken in by the medical community. As medicine established itself, a variety of organizations, institutions and individuals emerged to offer parturient care.

By the 1920s and 1930s, concepts of public health had been readily absorbed into medical rhetoric and language. Initially recognized as an "integration of

⁴⁸ See Appendix I for a list of health care developments in Manitoba from 1867 to 1950.

⁴⁹ For a full account of the developments of the medical profession in Manitoba, see Mitchell, *Medicine in Manitoba*, and Carr and Beamish, *Manitoba Medicine*.

sanitary science and medical science,"⁵⁰ the definition of public health expanded to incorporate a methodology and approach to health care delivery which focussed on medical preventative measures rather than medical treatment; i.e., public health was being conceptualized within the developing hegemony of organized medicine:

Public Health is the Science and Art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency through organized community effort for (a) the sanitation of the environment, (b) the control of communicable infection, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.⁵¹

By 1930, the medical community was aspiring to a rather broad mandate.

In the history of public health, it is usually epidemics of infectious disease which catalyze concrete applications of public health theory. The province of Manitoba, generally, and the city of Winnipeg, specifically, were historically unexceptional in this respect. However, while the province had established the rudimentary beginnings of a public health network by 1876, Winnipeg lagged behind in its local public health needs. Teeming with inhabitants, and struggling to control its constant stream of new arrivals, Winnipeg was unprepared for the smallpox threat of 1893. The city's infrastructure and health organization simply were unprepared, and unwilling, to implement the necessary measures of epidemic

⁵⁰ John J. Hanlon and George E. Pickett, *Public Health: Administration and Practice*, 7th edition. Toronto: The CV Mosby Co., 1979, 3.

⁵¹ Definition provided by C. E. A. Winslow in "The untilled field of public health," *Modern Medicine* 2, March 1920, 183. Cited in: Hanlon and Pickett, *Public Health*, 4.

control. Winnipeg city council was hesitant to support the major budgetary demands of a civic health department. Instead, it appointed a figure-head health officer in 1881. The health office did not have any significant impact until the first decade of the twentieth century. Even then, the primary focus of the department was on the overcrowding and poor housing conditions in the "foreign quarter."

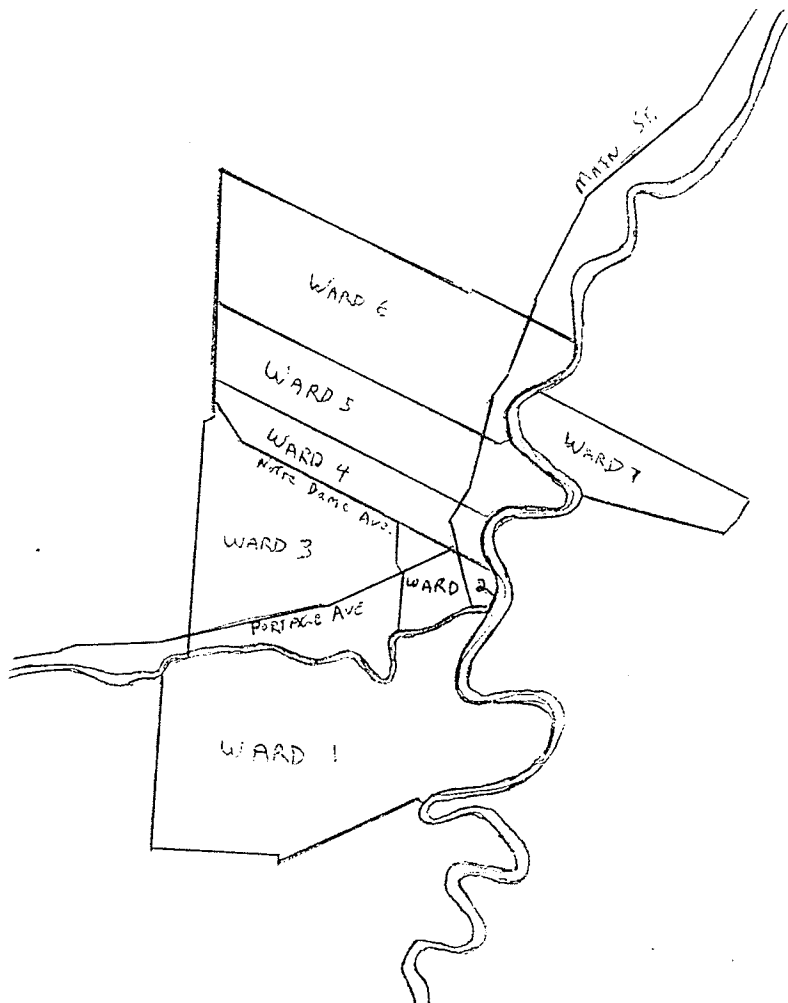
By the 1910's, the public health movement's focus on preventative medicine began to take root in Winnipeg. It raised alarms over high infant mortality rates. Spurred by concerns over alarming infant mortality rates, public health officials targeted ignorant mothers as the cause of infant deaths. The medical profession lauded the necessity for better prenatal care. Reinforcing the medical profession's claims, the city established and started to rely on public health nurses and institutions to convey a medicalized message of proper hygiene, diet and lifestyle.

The following chapters will detail some experiences of Winnipeg women in the newly-emerging medical culture for birth between the late 1800's and the early 1920's. While not completely engulfed in a medicalized model by WWI, childbirth and maternity care were becoming appropriated within the *modus operandi* of medicine. Institutions, such as the Salvation Army's Grace Maternity Hospital and the Winnipeg General Hospital, offered confinement care for the very poor and the very rich; the Margaret Scott Nursing Mission provided care for those working poor whose financial situation could not possibly allow for professional medical attendance. These emerging institutions contributed to the slow process of altering the birthing experience for the myriad of women - rich and poor, immigrant and native-born - who flooded into Winnipeg in the period leading up to WWI.

* * *

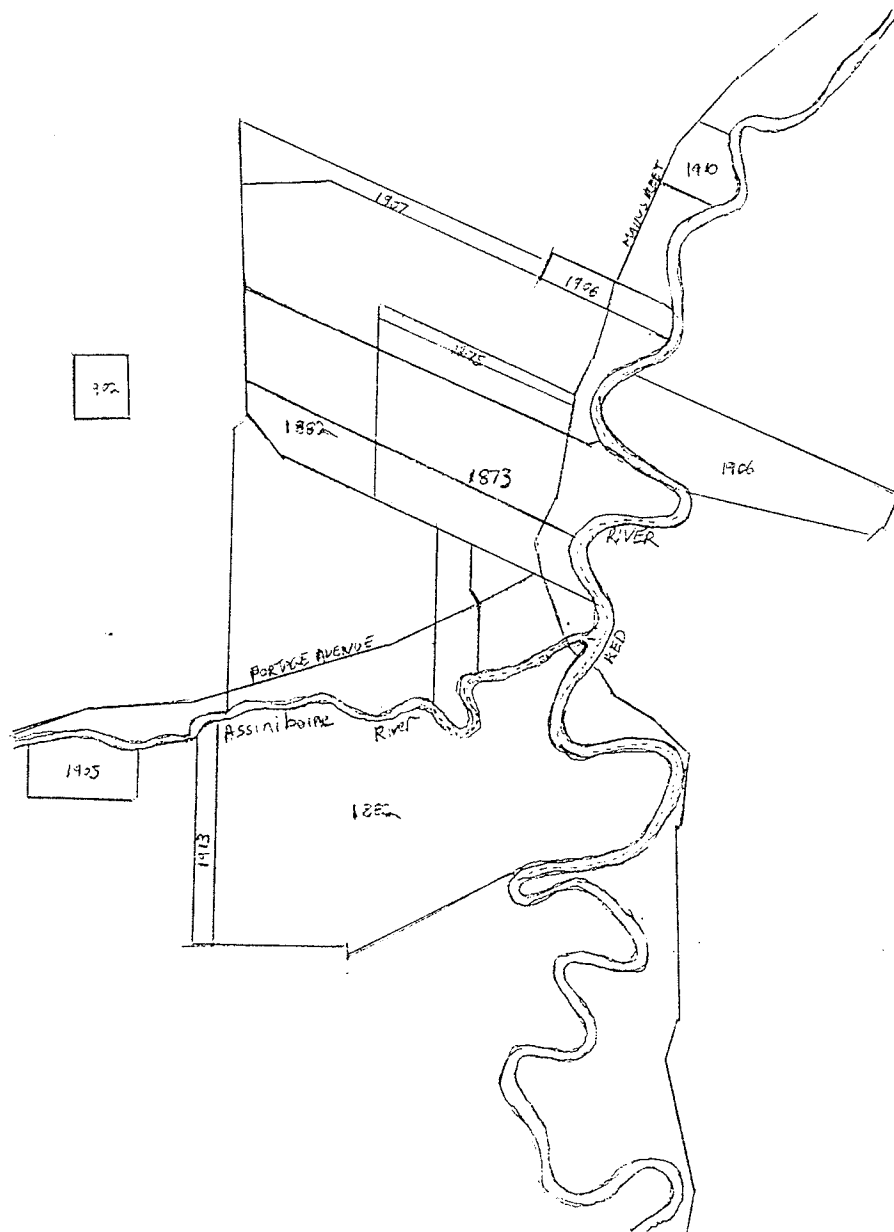
Winnipeg's gradual acceptance of public health doctrine provides an interesting window on the childbirth experience of Canadian women. While fully conscious of modern thinking and medical professionals, the city nonetheless moved forward slowly on public health initiatives. The result was a community that comfortably straddled old world childbirth traditions and modern maternity doctrine, creating a hybrid community and a unique historical window onto the Canadian childbirth experience.

Map 1



Ward Boundaries, Winnipeg, 1882-1919

Map 2



Territorial Annexation, Winnipeg, 1873 to 1913

Chapter 1, Appendix 1

Health and Medical Care Delivery in Manitoba, 1867 to 1950

- 1867 Establishment of the *Canadian Medical Association*
- 1869 Establishment of the *College of Physicians and Surgeons of Ontario, Ontario Medical Act* (first in Canada)
- 1871 Formation of the *Provincial Medical Board of Manitoba* (an elected a Board of Governors who set examinations for licensing and offered courses of instruction)
St. Boniface Hospital established by the Grey Nuns (4 beds)
- 1872 Board of Health formed and the *Winnipeg General Hospital* organized
- 1875 *Winnipeg General Hospital* incorporated
- 1877 Manitoba Medical Act
Formation of the *College of Physicians and Surgeons of Manitoba*
Expansion of *St. Boniface Hospital* (10 beds)
- 1882 Establishment of the Manitoba Medical School
Passage of *Winnipeg General* by-laws
Allowed for 3 consulting physicians (Drs. William Cowan, Jackes and O'Donnell)
and 6 attending (Drs. Lynch, Good, Codd, Kerr, Whiteford and R.B. Fergusson)
- 1883 Instruction begins at *Manitoba Medical School*
- 1884 *Winnipeg General Hospital* moves to its current location
- 1888 *Winnipeg Medico-Chirurgical Society* formed
- 1891 *Brandon General Hospital* built
- 1890 *Manitoba Medical Association* formed (no further record of activities or meetings)
Executive: M. Macklin (Portage), J.H. O'Donnell, J.W. Good, J.R. Jones
- 1893 Organization of the *Provincial Board of Health* with the passage of the Public Health Act in Manitoba - Drs. J.H. O'Donnell (chair), A.H. Ferguson, J.R. Jones, H.H Chown, H.A. Husband, Dr. Torrance, V.S. and J.H. Brock (co-founder of Great West Life)
- Additions made to the *Winnipeg General*
- 1898 *Misericordia Hospital* opened

- 1900 Formation of the *Winnipeg Clinical Society*
- 1904 Formation of the *Margaret Scott Nursing Mission*
Salvation Army Grace Hospital opened as a maternity hospital
- 1905 Branch of the *Victorian Order of Nurses* opened in Winnipeg
- 1908 *Manitoba Medical Association* formally organized
Executive: Drs. J.R. Jones, J.A. Macdonald (Brandon), J.R. McRae (Neepawa),
Jasper Halpenny, R.W. Kenny
- 1909 *Winnipeg Children's Hospital* opened
- 1911 Revision of the *Public Health Act*
Included inspection of milk, control of sewage, water, food
Victoria Hospital opened
- 1912 Additions made to the *Winnipeg General Hospital*
- 1913 Establishment of the *Winnipeg Medical Society* (merger of the Winnipeg Medico-Chirurgical Society and the Winnipeg Clinical Society)
- 1916 Engagement by the province of 5 public health nurses as an experiment
Provision made of *Chief Officer of Health* (Dr. Gordon Bell)
- 1917 Establishment of provincial public health nursing service within the Department of Health
- 1923 *St. Joseph's Hospital* opened
- 1928 Formation of *Ministry of Health and Public Welfare* (Dr. E.W. Montgomery)
- 1936 *Concordia Hospital* opened
- 1937 Establishment of the division of *Maternal and Child Hygiene* within the Department of Health
- 1938 *Pregnancy Survey* conducted in province (May 1, 1938 - April 30, 1940) in collaboration with the Department of National Health, Canadian Medical Association, Rockefeller Foundation and the College of Physicians and Surgeons of Manitoba
- 1950 *Maternity Pavillion* opened at the Winnipeg General

Sources: Mitchell, Ross. *Medicine in Manitoba: The Story of Its Beginnings*. Winnipeg: Stovel-Advocate Press, Ltd. 1954.

McPherson, Kathryn Mae. "Skilled Service and Women's Work: Canadian Nursing, 1920-1939." Ph.D. thesis, Simon Fraser University, 1989.

Chapter Two

"Wherever she bears her tender burden"¹: Childbirth in Early Twentieth Century Professional Literature

In the mid-nineteenth century, obstetrics was often considered the 'poorer cousin' of medical practice. Though doctors were summoned to attend births, devotion to the care of women during childbirth did not merit a unique specialty in the eyes of medical practitioners. "To many medical men," noted a Canadian physician in 1930, "obstetrical practice is sordid, drab, uninteresting, and unremunerative."² Some physicians even deplored the practice of midwifery. They felt the care of parturient women was beneath their profession: "I heard a physician say sometime ago that he would rather clean out the garbage can than attend a confinement."³

The sporadic attendances of male physicians meant that well into the twentieth century, female birth attendants, including family members and midwives, continued their traditional roles in childbirth management.⁴ The continuing belief, amongst the public and medical men alike, that midwives were appropriate attendants contributed to the professional notion that obstetrics, while necessary, was not a specialized part of medical

¹ Quote from Oliver Wendell Holmes, "Contagiousness of Puerperal Fever", 1843. Cited in Nathanson, "Prophylaxis in Obstetrics, with Special Reference to the Value and Importance of Pre-Natal Care", *Canadian Medical Association Journal*, 14, 1924, 497-98 (hereinafter *CMAJ*): "The woman about to become a mother, or with new-born infant upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden or stretches her aching limbs."

² C. B. Oliver, "Obstetrical Practice Yesterday and To-Day", *CMAJ* 22, 1930, 470.

³ S.P. Ford, "An Analysis of Three Thousand Cases of Obstetrics", *CMAJ* 7, 1917, 412.

⁴ Judith Walzer Leavitt, "'Science' Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century", *Journal of American History* 70:2, 1983, 281-282.

practice. Few physicians coveted the role of childbed attendant, in part because the care of birthing women was identified with midwifery and the female sphere.⁵

Canadian historians have demonstrated, either directly or through their studies of social reform campaigns which sought to eliminate midwives, that a community of women persisted to attend childbearing women well into the twentieth century and long after the appearance of physicians at the parturient bedside.⁶ Early on, physicians only attended childbirth cases when complications necessitated a medical presence. Moreover, those regular cases that were attended by physicians, revealed class distinctions amongst the patient base. At one extreme, there were the wealthy women with a growing faith in medical expertise who would pay handsomely for professional attendance. At the other extreme, were the poor and socially disadvantaged parturient women, coming to hospital out of desperation and fall under the care of the resident physician.⁷

⁵ Richard W. Wert and Dorothy C. Wert, *Lying-In: A History of Childbirth in America*, expanded edition. New Haven: Yale University Press, 1989, 145.

⁶ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1986; Cynthia R. Comacchio, *"Nations are Built of Babies": Saving Ontario's Mothers and Children, 1900-1940*. Montreal: McGill-Queen's University Press, 1993; Hélène LaForce, "The Different Stages of the Elimination of Midwives in Quebec", and C. Lesley Biggs, "Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900", in *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, Katherine Arnup, Andree Lévesque, and Ruth Roach Pierson, eds. London: Routledge, 1990, 36-50 & 20-35; Denyse Baillargeon, "Les rapports médecins-infirmières et l'implication de la Métropolitaine dans la lutte contre la mortalité infantile, 1909-1953," *Canadian Historical Review*, 77, 1, 1996, 33-61.

⁷ Frances Korbin, "The American Midwife Controversy: A Crisis of Professionalization", *Bulletin of the History of Medicine* 40, 1966, 350. See also Judith Walzer Leavitt. *Brought to Bed: Child-Bearing in America, 1750-1950*. New York: Oxford University Press, 1986, 38.

Towards the end of the nineteenth century, the Canadian medical profession solidified its status by combatting a myriad of alternative therapies and practitioners, including midwives.⁸ Science-based procedural approaches and treatment methods, coupled with a more general ideological shift towards professionalism, improved the overall reputation of physicians. “Although the profession’s authority and status were greatly increased by the discoveries and applications of biomedical science,” argues historian David Naylor, “other groups at the turn of the century were perceived as potential threats to medicine’s newly consolidated position.”⁹ As will be shown, however, physicians were relatively unfamiliar with the art and science of midwifery. Accordingly, they were peripheral figures in the birthing rooms. Ignorance concerning the female condition represented a vulnerability to medicine’s professional aspirations.¹⁰ After all, if the medical man’s performance in the birth chamber could be outdone by the local wise-woman, what chance did he have to solidify his reputation with the parturient woman’s family and friends, not to mention his colleagues?

This chapter argues that, in response to their marginalized positions in birthing chambers, physicians began to claim exclusive authority over medical elements of the birth process. They focussed on the medical components of the event, elements for which

⁸ Mitchinson, *The Nature of Their Bodies*, 166-174.

⁹ David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Kingston: McGill-Queen’s University Press, 1986, 22.

¹⁰ It should be noted, however, that while Canadian physicians opposed midwives, they did not mount an especially virulent or aggressive campaign against the practice. See Naylor, *Private Payment, Public Practice*, 23 and also Mitchinson, *The Nature of Their Bodies*, 162-175.

they could provide assistance.¹¹ In doing so, they de-emphasized broader, traditional notions of “social childbirth”. Once under professional directives, women’s *experience* of childbirth altered. The previous emphasis had been focussed on care of the mother as a whole human being. Now it was redirected towards the mechanics of the body and bodily responses to pregnancy. Medical rhetoric featured the successive segments of the labour process itself. The person of the mother was excluded. In acquiring control of childbirth, physicians substituted a medicalized for a traditional social model of care. By medicalizing what previously had been perceived as a natural occurrence, physicians were accorded professional authority and legitimacy.¹²

In order to construct their model, physicians analyzed the process of childbirth into manageable and diagnostic parts. Applying a scientific rationale, they systematized the biological cause and effect of pregnancy and parturition. Doctors looked at pregnancy as they would any other disease requiring appropriate medical therapy. They identified a treatment and monitored its course. In the outcome, the mother, who had been the focal point of social childbirth, disappeared behind the pregnancy.

The medicalized model allowed physicians to provide what midwives could not - the precepts of science and pain relief. Despite their poor obstetrical training and dearth

¹¹ "Social childbirth" refers to the extended care offered to the birthing mother by the community of women in attendance. This extended care included staying with the birthing mother’s family and performance of the birthing mother’s typical household etc.

¹² Consider here Foucault’s argument that the classification of a disease allowed for the rationalization of perceptions about that disease. See Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books, 1973, 7.

of knowledge, physicians were assisted in accessing birthing rooms by patients themselves. The latter, in fact, played a crucial role in the process.¹³ The promises of safer and less painful birth experiences - emanating from aseptic techniques, medical instruments and drugs - were eagerly sought out by Canadian women. Physicians availed themselves of the new opportunity as presence in the birthing room allowed them to learn more about the birth process. They translated their experiences and learnings into training and educational standards. Ultimately, by the 1920's, obstetrics became a fully-recognized medical specialty.¹⁴

A shift in the stature of obstetrics became discernible in the pages of the new profession's journals which began to espouse authoritative descriptions of the optimal treatment and care of parturient women. In Canada, the *Canadian Medical Association Journal* (hereinafter, *Journal*) and the *Montreal Medical Journal* (hereinafter, *MMJ*) - both nationally-recognized publishing bodies of the profession - offered physicians articles on the management and care of childbirth cases. First published in 1911, the *Journal's* primary purpose was to provide a recognized voice for medical professionals in the Dominion. As literary mouth piece for the Canadian Medical Association (established in 1867), the *Journal* chronicled the profession's attack against non-medically educated practitioners.¹⁵ At the turn of the century, physicians lacked the

¹³ This is Judith Walzer Leavitt's thesis in *Brought to Bed*, 196.

¹⁴ Wendy Mitchinson, *The Nature of Their Bodies*, 159.

¹⁵ David C. Naylor, *Private Practice, Public Payment*, 23.

professional reputations of current practitioners. They competed for authority and the market place with a host of *alternative* practitioners, such as homeopaths or osteopaths. Midwives were among the practitioners targeted by the newly solidified medical profession.

To achieve social status and monopolize business, physicians ingratiated themselves to the public and promoted the advantages of the medical trade to governments. In his study of Canadian medicine, Hamowy shows that the establishment of the Royal College of Physicians and Surgeons of Canada resulted in the creation of a central organizational body.¹⁶ Through provincial affiliates, the organization lobbied for the licensing of medical practitioners. So determined was the College to control the availability of irregular practitioners, it commissioned a prosecutor charged solely with the task of halting their activities.

The medical profession criticized midwifery in the pages of its journals, but did not necessarily mount a campaign specifically targeting midwives. Its approach was through the legal system, and the powers of the prosecutor's office. The business of birth could be professionally and financially lucrative. Economic self-interest was a recognizable factor in the profession's attacks.¹⁷ The physician sought to expand his market by developing a broader patient base. Parturient care provided a means of access

¹⁶ Roland Hamowy, *Canadian Medicine: A Study in Restricted Entry*. Vancouver: The Fraser Institute, 1984. See also Harold Perkin, *The Rise of Professional Society: England since 1880*. New York: Routledge, 1989, 4-16.

¹⁷ Hamowy, *Canadian Medicine*, 7-8.

to the entire family.¹⁸ Moreover, childbirth was endemic and continual. Its simple regularity promised a steady, if unglamorous, practice, and guaranteed predictable income. However, midwifery remained important to Canadian families. Its significance was evident in the public's unsympathetic reaction to medical efforts to stifle competition. The public particularly resented ordinances concerning midwifery.¹⁹

Midwives were not necessarily a direct threat to the profession of medicine. However, by charging less for essentially the same service, they undercut a significant portion of potential medical business. For childbirth attendance, midwives charged \$2 per case in the early 1900's.²⁰ Physicians charged significantly more. In September of 1902, the typical fee of one country doctor for an ordinary confinement was between \$5 and \$10, with additional charges for the use of the forceps (\$2) and travel of more than three miles (\$2).²¹ A hospital birth would have been even more expensive. For example, at the Maternity Hospital Centre in Montreal, the cost of confinement services averaged \$9.51.²² That remuneration for services was an issue among medical professionals in

¹⁸ Mitchinson, *The Nature of Their Bodies*, 170.

¹⁹ Hamowy, *Canadian Medicine*, 157.

²⁰ Mitchinson, *The Nature of their Bodies*, 169.

²¹ Fees information provided by a country doctor speaking before the medical section of the Canadian Medical Association in September, 1902. Citation found in J.R. Clouston Huntington, "The Country Practitioner of To-Day," *Montreal Medical Journal* (hereinafter *MMJ*), 1902, 780.

²² W.W. Chipman, "Problems of Obstetrical Practice," *CMAJ*, XIII: 6, 1923, 380.

Canada is evidenced by D. Mackintosh's 1902 Presidential Address to the Medical Society of Nova Scotia's annual meeting:

Medical men have rights as well as other people. They have a right - and it is even a duty - to provide for themselves and their families. They have a right to look after their own health, although this is often a most difficult matter. And with a view to these ends they have a right to charge reasonable fees and take adequate steps to collect them. God knows that the conscientious physician earns all he gets and a great deal he never will.²³

Mackintosh's tone illustrates how the gendered division between the public and private spheres, which had placed women at the bedsides of parturient friends and relatives in the first place, contributed to their dismissal from that same role. As long as women did not threaten the security of the male labour market, they were permitted to operate business endeavours. Early on in the history of the dominion, midwives worked within a private, female world. However, as the medical profession began bringing childbirth into the more public realms of their profession in the late nineteenth century, women's involvement into the public sphere threatened this market and male capacities as family providers. When this happened, the roles of women in the public sphere were called into question in order to safeguard the welfare of the family.²⁴ Thus, gender lessons learned from factory floors transported themselves into white-collar professions. Concerning the presence of women in the work force, an American contemporary noted:

²³ D. Mackintosh, "Presidential Address: The Mutual Relation of the Profession and the Public," *MMJ*, XXIX:7, 1900, 481.

²⁴ Alison Prentice, Paula Bourne, Gail Cuthbert Brandt, Beth Light, Wendy Mitchinson and Naomi Black, *Canadian Women: A History*. Toronto: Harcourt Brace Jovanovich, 1988, 137-38.

It is not for any real preference for their labor that the unscrupulous employer gives work to girls and boys and women, but because of his guilty knowledge that he can easily compel them to work longer hours and at a lower wage than men. It is the so-called competition of the unorganized, defenceless woman worker, the girl and the wife, that often tends to reduce the wages of the father and husband.²⁵

Many working-class and even middle-class families preferred midwives because they were affordable. Thus, as medicine sought access to middle-class markets, the pre-existent presence of midwife competition was an issue.

Of course, organized medicine did not couch its attacks on midwives and other 'irregulars' in economic terms. It argued, instead, that untrained and unlicensed practitioners endangered the health and incomes of patients. For example, virulent and ridiculing attacks on chiropractors and osteopaths, illustrating the profession's hostility towards non-licensed practitioners, characterized the first thirteen pages of the September 1921 edition of the *Manitoba Medical Bulletin*. While the *Bulletin*, speaking on behalf of the province's medical community, targeted a specific group of irregulars, its tone indicated the medical profession's disdain for the lack of training among all such professions:

The osteopathic demand for "fair play" is in truth a claim to favourable discrimination, which is manifestly unfair. The recognition of his claims would be clearly unjust to the public which is entitled to first consideration, for the osteopath himself admits that he is out of sympathy with many valuable scientific methods utilized in medicine, and takes the

²⁵ Citation from Samuel Gompers "Why Married Women Should Not Work," 1906. Cited in Mary Beth Norton, ed. *Major Problems in American Women's History: Documents and Essays*. Toronto: D.C. Heath and Company, 1989, 285.

more than questionable position that all diseases and ailments are alike curable by the single osteopathic treatment.²⁶

The medical profession eventually succeeded in ousting irregular practitioners from their health care niches. More specifically, professional attacks on midwifery contributed enormously, though not exclusively, to its extinction in Canada, allowing doctors to develop a professional monopoly over the delivery of parturient health care.²⁷ Historian Charlotte Borst has argued that physicians were able to eliminate midwifery so easily because midwives did not see the necessity to professionalize. Midwives were predominantly immigrant married older women with older children at home. Their involvement in midwifery was not as an income provider, but as a member of the community.²⁸

Beyond economics, changes in medical thinking and practice deeply affected the care of pregnant women. As physicians increasingly engaged in childbirth management, a scientific model of parturition replaced the traditional model. The new focus was reflected in medical literature. However, there was a catch which was recognized even by the medical community. Doctors knew little about the birth process. Their paucity of knowledge was addressed by the *Journal*. In 1917, Harry C. Swartzlander wrote, "Little is or can be said of progress in the management of labour. Our fathers made their

²⁶ "Osteopaths and the War", *Manitoba Medical Bulletin*, 1-2, 1921, 7-8.

²⁷ Dorothy C. Wertz, "What Birth Has Done for Doctors: A Historical View," *Women and Health*, 8:1, 1983, 7-24.

²⁸ See Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge, Mass.: Harvard University Press, 1995, 40-45.

diagnoses and managed their cases as well as we do to-day and with as good results except for the use of a few drug preparations of recent discovery."²⁹

Of all branches of medical enquiry at the turn of the twentieth century, obstetrics fell far below the others in terms of its medical and scientific research advances. Unlike specialties such as surgery or bacteriology, few internationally-recognized discoveries had altered its scope and direction. "There is no branch of medicine," admitted H.M. Little in the *Journal*, "that is so insufficiently taught or so badly practised as obstetrics."³⁰

Discoveries in bacteriology were beginning to alter the treatment of infectious diseases and the principles and practice of surgery in the early twentieth century. The practice of obstetrics demanded similar applications of microbiologic discoveries. Unfortunately, physicians were slow to recognize the need for this. "Rigid surgical technique took longer to establish itself in the labour chamber than in the operating theatre," wrote O. Bjornson, Associate Professor of Obstetrics in 1925, "and where to-day it would be difficult to find a gloveless surgeon, we would, perhaps, not have to seek far to find a gloveless obstetrician."³¹ Yet, as a specialty, obstetrics continued to attract adherents, despite its limited grounding in the medical curriculum, poor research performance, and uncertain future.

²⁹ Harry C. Swartzlander, "The Medical Treatment of Obstetric Cases", *CMAJ*, 7, 1917, 222.

³⁰ H. M. Little, "On Death and Disability Resulting from Childbirth", *CMAJ*, 1, 1911, 131.

³¹ Bjornson, "An Obstetrical Retrospect", *CMAJ* 15, 1925, 1236.

Undeterred by any modesty arising from theoretical and practical ignorance about reproduction, physicians continued to push themselves into turn-of-the-century birthing rooms. Though poorly prepared by medical education for obstetrical practice, physicians were more likely than irregular practitioners to be familiar with the general structure and function of the human body. This gave physicians an opening. It allowed them to dispense some form of advice to prospective mothers who were eager to hear anything that might alleviate the sufferings of childbirth.³² Armed with their broad knowledge of medicine and health, physicians projected authority. Though sometimes lacking in substance, this authority permeated their relationships with mothers in the birthing chambers.

A noticeable development in medicalized childbirth was the emergence of pre-natal care as a standard practice in attendance upon parturient women. Initially, the medical community was not completely in accordance with the validity of maternity clinics for pre-natal care. Certainly, the concept was not seen as important enough to be included in the medical curricula of recognized educational institutions much before the First World War.³³ By the early 1920s, however, concerns about high maternal mortality rates in both the United States and Canada led many physicians to adopt newer methods of controlling birth conditions. Many converted to the gospel of pre-natal attendance,

³² Chapter 3 discusses obstetrical training in medical education.

³³ J. R. Torbert, "The Prenatal Care of Obstetrics Cases", *CMAJ* 4, 1914, 1086.

especially for wealthier families whose concerns could influence professionals.³⁴ It was simply good business to accommodate those who could pay handsomely for services, and whose positive endorsement could circulate among other persons of money and reputation. Mothers with the financial means to explore a variety of avenues to alleviate some of the fears and sufferings of childbirth looked to the promise of scientific-based medicine over traditional care. If a physician could provide assistance, however meagre, both his financial needs and the patient's emotional needs were met through his attendance. Pre-natal care was a natural precursor to the birth itself. It assured the physician could control the mother's environment.

In her study of the U.S. Children's Bureau, a federally sponsored child and maternal health organization, historian Molly Ladd-Taylor has argued that the prenatal care of parturient women served a dual purpose, both practical and economic. On the practical side, the physician's general knowledge concerning the human body could facilitate proper nutrition; moreover, prenatal observation for complications could certainly contribute to a healthy pregnancy.³⁵ On the economic side, physicians gained access to a broad market. This, in turn, expanded their knowledge of the birth process and contributed to obstetrical research. Also, for a physician seeking a solid income, a successful maternity case usually associated the doctor with the family, so that he was

³⁴ "Editorial: Ballantyne and the New Midwifery", *CMAJ* 13, 1923, 441.

³⁵ See Molly Ladd-Taylor. *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932*. New Brunswick, N.J.: Rutgers University Press, 1986, 35.

called upon to attend future illnesses within the family.³⁶ No longer were obstetric patients the destitute mothers seeking shelter in the poor hospitals of the nineteenth century³⁷; physicians now had access to middle-class women who expected relief and assistance, and could pay for them. Pre-natal care not only provided physicians with a means of entry into the market, it also promised women healthier and safer births.

The emphasis on pre-natal care was not without genuine scientific support. As physicians attended more births, they inevitably learned more about the body's condition during birth and, with greater efficiency, were able to recognize potential complications, such as a misshapen birth canal. By the 1910's, for example, doctors could identify headache, visual disturbances, vomiting or epigastric pains as danger signals of eclampsia³⁸ for which they prescribed rest, diet and drugs.³⁹ In the case of pre-eclamptic symptoms, therefore, a physician had cause to direct the daily activities of his patient.⁴⁰ It

³⁶ Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality", in *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1930s*, Linda Kealey, ed. Toronto: The Woman's Press, 1979, 133.

³⁷ Leavitt, *Brought to Bed*, 76-77.

³⁸ Eclampsia is defined as "coma and convulsions that may develop during or immediately after pregnancy, related to proteinuria (excretion of any protein in the urine), edema (a perceptible accumulation of excessive clear watery fluid in the tissues), and hypertension (high arterial blood pressure)", in *Stedman's Medical Dictionary*, 21st edition. Baltimore: The Williams and Wilkins Company, 1966, 499.

³⁹ Wertz and Wertz, *Lying-In*, 146.

⁴⁰ For a full description of the eclamptic condition, see J. J. Ross, W. W. Chipman, and J.R. Goodall, "Childbirth Complicated by Eclampsia," *MMJ*, 38:4, 1904, 267-277. Note that the cases described here were not initially diagnosed by the physicians until the onset of puerperal convulsions.

was a short step to move from cases of eclampsia, the symptoms of which seemed relatively minor, to offering advice in non-complicated pregnancies. Early diagnosis would often alleviate patient fears, enabling patients to face pregnancy more confidently under the watchful eye of science in the embodiment of the physician.

Given doctors' limited knowledge of the birthing process, the scope of pre-natal care was surprisingly large. Pre-natal prescriptions expanded to include all aspects of maternal life, from conception to early infancy. Consequently, if only in theory, the role and expertise of the physician increased dramatically. The broadened scope of ante-natal care impressed even the medical community. Upon the death in 1923 of a prominent advocate of pre-natal care, Professor J.W. Ballantyne, the *CMAJ* editorialized:

The extent [of pre-natal care] is remarkable, calling as it does for the development of ante-natal clinics, ante-natal wards, dental clinics, venereal disease clinics, venereal disease wards, post-natal clinics for the teaching of mothercraft to women, special wards for premature babies, and beds for reconstructive (gynecological) work, side by side with the lying-in wards.⁴¹

Through pre-natal care, then, the physician administered advice on all aspects of mother's life.

The Canadian Mother's Book, written by Helen MacMurchy and distributed by the federal government through the Department of Health as a means to combat high maternal and infant mortality rates, championed the breadth of pre-natal advice advocated by physicians. The book prescribed every facet of an expectant mother's daily routine. What type of clothes she wore, what and when she ate, what activities she undertook - all

⁴¹ "Editorial: Ballantyne and the New Midwifery", 1923, 442.

these fell under the jurisdiction of medical directive informed by the medicalized model of childbirth.⁴² MacMurchy's built a successful career through the use of her "pen, platform and position to reinforce the values of home and motherhood."⁴³ In relation to pregnancy and childbirth, her views were representative of the profession at large, despite her unusual status as a female professional in a very male-dominated field.

MacMurchy's perceptions of maternity patients and her views as expressed in the *Mother's Book* were similar to those of her male medical colleagues. A *CMAJ* article of the period captured the medicalized model supported by the profession at large. The author, W. P. Tew, argued that there were four groups of difficulties in obstetrics practice: the ante-natal pregnancy period, the ante-natal period, the labour period and the post-partum period.⁴⁴ In other words, a woman was always either preparing for pregnancy, pregnant or recovering from pregnancy, and therefore, always subject to certain medical risks. This assumption underlay doctors' collective approach to the childbirth experience:

One may say that the difficulties and emergencies of obstetric practice begin some time previous to the occurrence of pregnancy, and do not end for at least two months or more postpartum. Following this two months' postpartum period we will classify the patient as gynecological.⁴⁵

⁴² Helen MacMurchy, *The Canadian Mother's Book*. Ottawa: F.A. Acland, 1925. For a further discussion of MacMurchy and the Department of Health, see Chapter Four.

⁴³ Kathleen McConnachie, "Methodology in the Study of Women in History: A Case Study of Helen MacMurchy, M.D.", *Ontario History* 75:1, 1983, 64.

⁴⁴ W. P. Tew, "Certain Difficulties and Emergencies of Obstetric Practice," *CMAJ* 17, 1927, 1468.

⁴⁵ Tew, "Certain Difficulties," (1927), 1468.

The medical model was an image of illness, with the patient perpetually at risk. As French philosopher Michel Foucault noted in his epochal study of medical perception, the question changed from "what's the matter with you?" to "where does it hurt?". The latter question, by emphasizing the rhetoric of illness, reinforced the clinical culture and the reason for being of medicine.⁴⁶

In the case of pregnant women, the focus shifted from the condition of the mother as a person, to the analysis and diagnosis of her symptoms. The profession necessitated that the language used to discuss pregnancy conform to standard medical terminology. The tone of this language was communicated by W.P. Tew in his article:

The toxic conditions which commonly occur during pregnancy are namely: vomiting of pregnancy; ptyalism (*excessive saliva*); haemorrhage from the placental site (*bleeding*); neuritis (*numbing of nerves*); neuralgia (*nerve pain*); fibrositis and myositis (*rheumatism and muscle inflammation*); pruritus (*itching*); certain skin eruptions (*pimples*) (italics added).⁴⁷

Within the medical model, the body's normal responses to pregnancy, which had previously been taken for granted, were labelled as symptoms and monitored by the watchful physician. Medical journals were replete with earnest attempts to classify the 'symptoms' of pregnancy, and to provide 'treatment' for same.

That which had been previously considered to be a matter of physiology and development, was now construed as pathological. Considering the aetiology of

⁴⁶ Michel Foucault, *The Birth of the Clinic*, xviii.

⁴⁷ Tew, "Certain Difficulties", 1927, 1469.

pregnancy-associated light nausea and vomiting, David Evans, writing a century ago in the *Montreal Medical Journal* listed a host of disordered causes:

Exactly how conditions about the uterus give rise to peripheral irritation has been variously explained. Mechanical pressure on the enlarging uterus on the nerves of the pelvic ganglion; stretching of the muscle fibres of the uterus causing pressure on the nerves; versions and flexions of the pregnant organ; ovarian irritation from the uterine pressure; diseased conditions, as endometritis, cellulitis, endocervicitis, etc., have all been advanced as factors in the production of this irritation.⁴⁸

The technical terminology used in medical journals, intended to examine pregnancy under a microscope, was aimed specifically at other professionals. Its most striking feature was that it was used to describe both normal and abnormal pregnancy. Indeed, it is as if no pregnancy could be normal, despite token acknowledgement of its "physiological" nature. In an article entitled "Normal Labour", N. Preston Robinson declared:

Pregnancy is not a disease, but a physiological incident, and can be maintained as such by the observant and ready physician. Let us not wait, then, until serious manifestations of albuminuria are apparent or the blood becomes surcharged with bilirubin and biliverdin, urea or uric acid; but set about without delay by the ordinary eliminative processes, to rid our patient of the waste products retained in the blood.⁴⁹

The implication was that pregnancy was normal, but could remain so only if the physician was vigilant and active. It is as if the very 'ordinariness' of pregnancy, its

⁴⁸ David Evans James, "On the Ætiology of the Nausea and Vomiting of Pregnancy", *MMJ*, 29:2, 1900, 93.

⁴⁹ N. Preston Robinson, "Normal Labour", *MMJ*, 31:10, 1902, 771.

"physiological" nature, was to be converted into a medical condition worthy of physician attendance.

Even when they were not addressing colleagues, physicians adopted a language with regard to pregnancy which reinforced the idea that it was a medical condition. Mitchinson has argued that the medical and social worlds were interconnected in relation to women's health issues, and that scientific legitimacy gave physicians an authoritative role which allowed them to mould the way women perceived their own bodies.⁵⁰ Advising obstetrical nurses in 1909, a McGill University obstetrician warned: "It seems unnecessary to remind you that the pregnant woman is peculiarly liable to disorders of metabolism from the fact that she is ingesting, digesting and excreting for two individuals."⁵¹ Thus, in medical rhetoric, ordinary functions of everyday life - eating and processing food - were dangerous for the pregnant woman.

Pregnancy as a medical condition was not simply a matter of physical functioning for physicians. It was the central focus of the pregnant woman's emotional functioning as well. Emotional responses were also symptoms. "That there exists in the pregnant woman a condition of exaltation of nervous tension all are agreed," wrote David Evans.⁵² The emotional state of the mother, therefore, was also put in evidence for medical

⁵⁰ Mitchinson, *The Nature of Their Bodies*, 8.

⁵¹ Little, H.M., "On Obstetric Nursing," *MMJ*, 38, 8 (Aug., 1909), 486.

⁵² Evans, "On the Ætiology of Nausea and Vomiting," 93.

assessment. Not only were her daily routines scrutinized, but her thoughts and feelings also found their way under the medical microscope.

Emotional symptoms during pregnancy could be ominous in tone; or they could assume the form of "silly ideas". In the *Mother's Book*, childbirth was described as "the right, natural and healthy thing," and as a woman's "greatest happiness." But silly ideas could intrude. The medical treatment was simply to dispel such fears and concerns:

A sensible woman like you knows better than to "worry" or "fuss"! Keep up your heart and keep up your health. If you have a few silly ideas come into your head, just put them out again and think of something "pure, lovely and of good report." We all have silly ideas come into our heads sometimes, but they do no harm if we just think of something else, and go out for a walk. Cheer up! [emphasis added]⁵³

Within the medical model, the mother was responsible primarily for maintaining her emotional health. The warning issued in the *Mother's Book* was that no harm would come, if mother could "cheer up".

Beyond the pep and bravado, however, the facts reveal that doctors in the early 1900's could do little to address the concerns of mothers. In addition to high maternal mortality rates, doctors were very much aware of the health toll on a woman's life attributable to pregnancy: "Fifty per cent of women who have borne children carry the marks of injury and many date a life of permanent invalidism from the birth of their first baby."⁵⁴ Given the high relative risks of death and injury from childbirth, no assurances

⁵³ MacMurphy, *Canadian Mother's Book*, 9.

⁵⁴ C.B. Oliver, "Obstetrical Practice Yesterday and To-Day," *CMAJ*, 22, 1930, 470.

from doctors, despite their presence and use of science, could allay the fears of parturient patients.

These concerns over high rates of infant and maternal deaths in the late 1910's and throughout the 1920's spurred the pre-natal care campaign. The initial focus of the medical community and social reformers was the battle against infant mortality, construed to be "one of the great national, social and economic problems."⁵⁵ In 1908, the total infant mortality rate was determined to be 120 per 1000 births, one of the higher rates in the British colonies.⁵⁶ In some instances, the causes of infant mortality were readily identifiable in social circumstances, such as poverty. "Poverty means poor health for the mother, lower intelligence, lack of energy, and general insufficiency, and forces families to live in crowded insanitary surroundings."⁵⁷ More often, however, mothers were the easier targets. Health reformers pointed accusatory fingers at mothers and concentrated on mother education as the means of addressing the problem.⁵⁸ Women acquired roles in health reform rhetoric as mothers or potential mothers. Addressing the health situation of parturient women was a short step from tackling infant health conditions. Whether or not there was an integral direct or indirect link between the infant

⁵⁵ Alan Brown and George Campbell, "Infant Mortality," *CMAJ*, 4, 1914, 690.

⁵⁶ C. A. Hodgetts, "Infantile Mortality in Canada", *CMAJ*, 1:8, 1911, 721.

⁵⁷ Brown and Campbell, "Infant Mortality", 693.

⁵⁸ Cynthia Comacchio Abeele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1918-1940", *Ontario History* LXXX:3, 1988, 183.

mortality rate and the education of mothers, the former declined over the course of the 1920's.⁵⁹

The maternal mortality rate, however, did not diminish, despite an increase in professional attendance at childbirth. According to the 1880 Census, the maternal mortality rate was approximately 3.6 deaths per 1000 births.⁶⁰ By the 1920s, the maternal mortality statistics actually increased, rising to well above 5 deaths per 1000 births between 1926 and 1930.⁶¹ The medical journals decried the situation. "When we examine the vital statistics of the community and find that the number of deaths directly or indirectly attributable to childbirth is second only to that of tuberculosis during the reproductive years," wrote one Toronto physician, "we are compelled to pause and take stock of ourselves."⁶²

Perhaps the primary catalyst of the maternal welfare campaign was Helen MacMurphy's study of maternal mortality in Canada for the period between July 1, 1925 and July 1, 1926. The study reviewed the deaths of over 1,200 patients by distributing a questionnaire to the signatory of the death certificate.⁶³ While MacMurphy refrained from drawing broad conclusions, the focus of her analysis was clear - most deaths in childbirth were preventable. In reply to the simple question "What are we to do?",

⁵⁹ See Appendix 1.

⁶⁰ Cited in Mitchinson, *The Nature of their Bodies*, 228.

⁶¹ F. H. Leacy, *Historical Statistics of Canada*, Series B51-58.

⁶² W. B. Hendry, "Maternal Mortality," *CMAJ*, 13, 1923, 252.

⁶³ Helen MacMurphy, "Maternal Mortality in Canada," *CMAJ*, 17, 1927, 1434.

MacMurchy responded, "We must educate the mother about the need of pre-natal care."⁶⁴ In this, MacMurchy was perfectly consistent with her medical colleagues. Physicians perceived professional attendance from the very beginnings of pregnancy as the best means of controlling the monstrous maternal mortality rate. Even in the mid-1910's, physicians were alluding to the benefits of pre-natal care. A 1914 study at the Pregnancy Clinic of the Boston Lying-in Hospital, where pre-natal attendance was regularly practised, revealed a maternal mortality rate of 3.28 deaths per 1000 births, a figure significantly lower than the Dominion Bureau of Statistics 1925 report which cited for 1924 a maternal mortality rate of 5.6 per 1000 births.⁶⁵ Publication of this article in the *Journal* attested to the Canadian medical profession's interest in pre-natal care.⁶⁶

About the time of MacMurchy's study, the interest in pre-natal care within the professional community was at its strongest. Physicians referred to their own practices and experiences to support the importance of ante-natal attendance. A Manitoba physician noted that at the Winnipeg General Hospital, between 1917 and 1920, the maternal mortality rate was 10.8 deaths per 1000 live births. Following establishment of

⁶⁴ Helen MacMurchy, "Maternal Mortality in Canada," 1437.

⁶⁵ Torbert, "The Prenatal Care", 1914, 1090.

⁶⁶ As the publishing organ for the medical profession in Canada, the *Journal* addressed issues that were of interest to Canadian physicians. Whether or not they agreed with pre-natal attendance, the presence of such articles indicates Canadian professional interest.

a pre-natal clinic in 1921, the rate dropped to 5.14 deaths per 1000 births for the period between 1921 and 1930.⁶⁷

By the 1920s, calls for safer childbirth reverberated throughout the social reform and political arenas.⁶⁸ Many of the most vocal proponents of reform were women, such as Helen MacMurchy, and mothers, who saw childbirth as a maternal responsibility to the nation.⁶⁹ They affirmed that the "nation" owed mothers, in return, the best maternal care possible. For many, pre-natal care was the medical profession's best response to public concerns related to pregnancy and childbirth.

Physicians, too, contributed to the furor over high maternal death rates. The *Journal* published several articles between 1910 and 1930 covering the high toll of childbirth to the population of mothers.⁷⁰ To combat maternal death, physicians re-emphasized the benefits of pre-natal care and underscored their role in the management of

⁶⁷ Ross Mitchell, "The Prevention of Maternal Mortality in Manitoba", *CMAJ* 19, 1928, 295.

⁶⁸ See Dianne Dodd, "Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women" in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. Ottawa: University of Ottawa Press, 1994, 150-153.

⁶⁹ MacMurchy, *Canadian Mother's Book*, 8.

⁷⁰ In addition to those already mentioned, other articles with "maternal mortality" in the title included, but were not limited to: Helen MacMurchy, "On Maternal Mortality in Canada", *CMAJ* 15, 1925, 293-297; James Young, "Maternal Mortality from Puerperal Sepsis", *CMAJ* 19, 1928, 227-233; A.D. Blackader, "Thoughts on Maternal Mortality", *CMAJ* 20, 1929, 656-657; "Editorial: The Problem of Maternal Mortality", *CMAJ* 21, 1929, 432-433; J. R. Goodall, "Maternal Mortality", *CMAJ* 21, 1929, 447-450; "Editorial: Maternal Mortality and the Practice of Obstetrics", *CMAJ* 20, 1929, 180-181; M. R. Bow, "Maternal Mortality as a Public Health Problem", *CMAJ* 23, 1923, 169-173.

pregnancy. "Drag the subject of the pregnant woman out into the light of day," wrote Manitoba's Minister of Public Health and Welfare, E. W. Montgomery. "Make all authentic information regarding diet, exercise, hygiene, medical and nursing care, at least as widespread and as interesting to the public as information which is now generally circulated regarding the feeding and care of children."⁷¹ Physicians had obtained licence, with full public support, to delve into all facets of maternal lives.

A typical maternity clinic visit addressed the physical, social and cultural components of the mother's life and habits. An Ottawa physician, J. N. Nathanson, noted in the *Journal*:

When a woman presents herself to us after she has become pregnant, she should be impressed with the idea that until she has given birth to her child, and the generative organs have gone through the period of involution, her physician holds himself in constant readiness to render her whatever assistance or advice she may desire or be in need of. He should not wait for her to volunteer subjective complaints, but rather must be on the qui vive for all those abnormal deviations which may and do occur so often during pregnancy.⁷²

As implied by Nathanson's directive, intimate details of a woman's life now fell within the medical man's scope. The standard course of inquiry for a pre-natal visit was extensive. On her first visit the patient was to be "closely questioned as to her past history . . . Similarly should the patient be interrogated as to the occurrence of venereal disease . . . a thorough and carefully obtained history often discloses to the medical

⁷¹ E. W. Montgomery, "Maternal Mortality", *Canadian Public Health Journal* 21:5, 1930, 223.

⁷² Joseph N. Nathanson, "Prophylaxis in Obstetrics, with Special Reference to the Value and Importance of Pre-Natal Care", *CMAJ* 14, 1924, 496.

attendant the possible abnormalities which may affect the patient".⁷³ Nathanson's language is surprisingly accusatory in tone. The patient is 'closely questioned' and 'interrogated' about her health and her condition.

Nathanson went on to describe the course of the physical examination, which was to include a thorough hands-on examination of cardiovascular, pulmonary and excretory systems, blood pressure, urinalysis, abdomen and pelvis. The examination was to encompass as well aspects not necessarily directly associated with the reproductive cycle, such as teeth and tonsils.⁷⁴ The objective of the entire exam was to uncover the abnormal in order to prepare for complications. The patient's entire body and psyche were to be considered in the light of pre-determined standard measures from which "abnormal deviations" could be identified. Thus, physicians claimed a knowledge of the normal course of pregnancy founded on little more than their presumed expertise and authority. The developing medical notion, as espoused by a Chatham, Ontario physician, was that a pregnant woman is always "travelling close to the border-land of pathology and she needs a guide familiar with every shallow and quicksand and portage along the way."⁷⁵ The language was rather dramatic, but the message was clear. A more active role for the physician in the treatment of pregnant patients was being promoted. This distinguished obstetrics from mere accouchement.

⁷³ Nathanson, "Prophylaxis in Obstetrics", 496.

⁷⁴ Nathanson, "Prophylaxis in Obstetrics", 496-97.

⁷⁵ Oliver, "Obstetrical Practice Yesterday and To-Day", 473.

The physical examination element of pre-natal care lay squarely within the physician's perceived field of expertise, the physical development during pregnancy of both the mother and fetus. The goal of pre-natal clinics was to offer complete physical exams, including laboratory tests where necessary. Toronto physician W.B. Hendry described the standard procedure of a pre-natal visit: "The expectant mother comes there and is given a complete physical examination, has her pelvic measurements taken, urine examined, [and] blood pressure noted."⁷⁶ To the extent of this physical assessment, the field of medical science was not without merit. By the 1910's, as previously noted, physicians were able to identify several physical problems during pregnancy which endangered the lives of mother and baby, including eclampsia and maternal syphilis. Moreover, medicine was able to identify gynaecological obstacles, such as contracted pelvis, which would make birth more difficult, and potentially dangerous.⁷⁷

Armed with relatively new surgical techniques, doctors could lessen the danger in "complicated" cases by performing a Caesarian section. "In the old way", noted A. Mackinnon, "one life, rarely two, was saved after a desperate fight, lasting sometimes a day or two. By Caesarian section, after mature consideration, prompt decision and immediate action, all anxiety is practically removed in one hour."⁷⁸ The key descriptors

⁷⁶ Hendry, W. B., "Maternal Mortality", *CMAJ* 13, 1923, 253.

⁷⁷ Wertz and Wertz, *Lying-In*, 140.

⁷⁸ A. Mackinnon, "Caesarian Section", *CMAJ* 12, 1922, 406.

here were "prompt" and "immediate". The doctor's intervention was based on decisions for which lengthy pre-natal care was an absolute necessity.

Physical assessment, however, was but the first stage of a complete review of the mother which contemplated her suitability to bear children. To the extent to which medical judgment intruded into non-physical areas, it exceeded its expertise. However, organized medicine could not be characterized as modest. Physicians were undeterred as they moved to dimensions beyond the physical. The typical maternity visit included prescriptions for everything from diet to dress. The physician's new role as protector offered him a license to dictate patient behaviour generally. Medical maternity care reinforced stereotyped social and cultural beliefs about women. As every aspect of a woman's daily life was increasingly subjected to medical scrutiny, the language used by physicians became accusatory in tone. Nathanson warned:

The patient should be instructed as to her personal hygiene, the type of housework she may carry on, her mode of living, the recreations in which she may indulge, etc., and if on interrogation, any or all of these should be found to be faulty, then it is incumbent upon the physician to rectify them.⁷⁹

The physician's moral and social standard was less a reflection of science than that of his culture. Nathanson's use of the word "faulty" implied that the mother might be 'wrong' in the way she conducted her daily life. The tone revealed the adoption of an authoritative position in relation to the general well-being of mother and baby. Put simply, the doctor knew best, and given that what was at stake was no less than the lives

⁷⁹ Nathanson, "Prophylaxis in Obstetrics", 1924, 496.

and health of herself and her child, he had the authority to correct his female patient. The use of the word "rectify" is also instructive. Not only was the physician the keeper of the norm, he was charged with altering behaviours that did not conform to the appropriate, accepted and acceptable code of conduct. It was the responsibility of the medical profession to remedy those behaviours not deemed appropriate for an expectant mother.

Professional stature authorized and justified physician inquiries concerning the private lives of their patients without transgressing social expectations or offending delicate natures. The intrusiveness was reinforced by their developing conviction that it was necessary to provide pre-natal care in the homes of their patients, rather than wait for their patients to attend on them. "These women cannot come to us in our hospitals and training-schools", wrote W. W. Chipman of McGill University, "We of these schools must go to them".⁸⁰ Few pregnant women in the Victorian period consulted a physician. Exceptions included the destitute refugees of lying-in hospitals and the wealthy, whose previous complications necessitated professional care.⁸¹ The willingness of physicians by the 1920's to seek out obstetric patients created a new form of relationship in the birth chamber, and restructured the politics. No longer were doctors summoned only for emergencies; they were slowly adopting the role of regular consultant during pregnancy and parturition. Ultimately, this contributed to a shift in the balance of power in the birth situation, from patient to her physician.

⁸⁰ W. W. Chipman, "Problems of Obstetrical Practice," *CMAJ* 13, 6, 1923, 380.

⁸¹ Mitchinson, *The Nature of their Bodies*, 195.

Despite the fact that the human body remained a relative mystery to most medical practitioners in the early twentieth century, the principles of science accorded physicians an overarching authority anyway. American historian Charles Rosenberg, in his study of nineteenth century medicine, argues that science obtained its authority through an association which was made between scientific order and divine law. Early scientific dictums and formulations were rooted in a belief in the natural order of the world as laid down by divine creation:

Just as naturalists and physical scientists assumed that their research illuminated the glory of God in his works, so did most nineteenth-century... physicians assume that there could be no conflict between their findings and the truths of morality. The human organism was a thing both material and divine, and offences both physical and moral were necessarily punished with disease.⁸²

This link seemed to have been made by Canadian physicians as well. By the early twentieth-century, science had distanced itself from divinity, but it still retained a secularized authority over the natural development of the human body. In his 1902 address to the Medical Society of Nova Scotia, Dr. Mackintosh had voiced the profession's belief in its role as societal protector:

There are many social and domestic problems with which the physician is peculiarly qualified to deal. His intimate relations with the members of society as a family physician give him many opportunities of learning the secret vices that are sapping the foundations of the social fabric. It is not

⁸² Charles E. Rosenberg, *No Other Gods: On Science and American Social Thought*. Baltimore: Johns Hopkins University Press, 1976, 10-11.

enough that he should warn privately those whose follies are undermining their physical constitutions. It is necessary sometimes that public action be taken to protect society and especially the youth of our communities against contamination and vice versa. We should have the moral courage to denounce what is debasing and dangerous in social life and customs. The physician should also identify himself with all the measures looking to a betterment of the intellectual, educational, industrial, and recreative pursuits of the people.⁸³

In secularizing nature, science offered physicians a clerical role as safe-guarders of body, soul and nervous system. Consequently, it was not such a big step for physicians to assume the role of birthing experts. The traditionally-considered natural phenomenon of birth was being accorded a new scientific identity; the medical profession was perceived to be the keeper of the mysteries of science in the domain of birth and everything pertaining to it.

In addition to accessing the homes of patients, physicians encouraged women to visit pre-natal clinics and medical offices. Such a change in location of consultation, signalled a shift in the doctor-patient relationship.⁸⁴ Whereas formerly patients were in contact with physicians on the day of birth only, either in home or hospital, in travelling

⁸³ Mackintosh, "Presidential Address," 486.

⁸⁴ Note that this refers to physician attendance only. As will be shown in a later chapter, nurses provided pre-natal care in the homes of patients.

to doctors' offices and pre-natal clinics, a precedent was established which would entrench itself for the remainder of the twentieth century. Removal from familiar surroundings and the community of women may have subjected mothers to physician authority in a less diluted and more direct manner. Over the course of time, this probably further bolstered medical authority. However, the regular removal of birth from the home was not an immediate occurrence. At least for the first few decades of the twentieth century, physicians found themselves travelling to women.

Pre-natal visits became so entrenched in medical rhetoric that they appeared in the profession's discussions concerning maternal health insurance. Historian Denyse Baillargeon has studied the *Metropolitaine Insurance Company's* involvement in the campaign against infant mortality. She has shown that visiting nurses were engaged by the company to disseminate pre-natal information among company clients, until physician opposition put an end to it.⁸⁵ The profession likely had a vested interest in the promulgation by insurance companies of pre-natal advice. It saw itself fit to comment on the nature and appropriate scope of insurance benefits. In an article examining obstetrics and the state, K. C. McIlwraith offered guarded approval for insured maternity care: "Many countries have followed this course, but I could not undertake to urge it without further study of the results produced . . . As the insured contributes to the fund, her right to cash benefits cannot be denied, but I am opposed to cash benefits by the State."⁸⁶

⁸⁵ Denyse Baillargeon, "Les rapports médecins-infirmières", 35.

⁸⁶ K. C. McIlwraith, "Obstetrics and the State", *CMAJ* 10:4, 1920, 305-313.

McIlwraith's position had less to do with the nature of care, and more with the payment of benefits. Physicians had a great interest in the structure of medical insurance programs, and readily involved themselves in discussions.⁸⁷

A second central issue of the medical literature pertaining to childbirth in the 1910s and 1920s was the profession's desire to find an appropriate balance between the provision of active assistance and what contemporary physicians referred to as "meddlesome midwifery". While this derogatory appellation impugned midwives, it was used equally to criticise the intrusive techniques adopted by many obstetric physicians. The *Journal* abounded with descriptions of horrific partum situations in which the life of the mother was imperilled, not just by unhygienic home surroundings, but also by the technical interference of her physician. "Above all, he [the physician] must not only know when and how to interfere, as the emergency arises," declared the Ottawa doctor Joseph Nathanson, "but also when not to interfere, for 'meddlesome midwifery' is one of the greatest dangers surrounding the practice of obstetrics today."⁸⁸

Physicians attended pregnant women mostly in their homes from the late 1800's until the 1940's. In the first two decades of the twentieth century, they were often hindered and frustrated by the disadvantaged conditions they encountered - especially in the homes of the poor. Though they decried the unsatisfactory and sometimes horrible

⁸⁷ For a discussion of the profession's involvement in Canadian health insurance debates, see C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Montreal: McGill-Queen's University Press, 1986.

⁸⁸ Nathanson, "Obstetrics and the State," 495.

surroundings, they were unable for the first half of the century to make significant headway in removing patients to hospitals. In 1926, only 17.8% of Canadian births were in hospital.⁸⁹ Most Canadian women bore their children at home. Commenting in 1923 on one of the reasons for the high proportion of home births, the Montreal practitioner W.W. Chipman claimed, "[i]n 90% of all cases, the labour is spontaneous, and . . . a vast proportion of these mothers must be delivered in their own homes."⁹⁰ Though we know little about popular attitudes, it appears that most women failed to consider the hospital an appropriate place to give birth. For most women, the home seemed the only suitable setting for confinement. Only the unwed or the very poor sought attendance in a maternity hospital.⁹¹

While prevailing conditions required acceptance of the home-birth situation, professionals condemned the circumstances they found and emphasized the dangers. The most extraordinary cases were written up in the *Journal*, giving the impression that most home births were tainted by filth and ignorance. K. C. McIlwraith described at length one of his encounters in downtown Toronto:

I had to stoop to enter the low-browed shop, slipped awkwardly on the greasy floor, and landed in the bosom of the family. There they stood, clad in rags, dirt, and long beards, solemnly staring. I asked for some means of washing my hands, and was shown a filthy kitchen, where in a dirty sink, stood the remains of the last meal, and the beginnings of the

⁸⁹ F. H. Leacy, M. C. Urquhart and K. A. H. Buckley, eds. *Historical Statistics of Canada*, first edition. Ottawa: Statistics Canada, 1983, plate B1-14.

⁹⁰ W. W. Chipman, "Problems of Obstetrical Practice," *CMAJ* 13:6, 1923, 380.

⁹¹ Alison Prentice et al. *Canadian Women*, 167.

next, with a feeble trickle of cold water running over them, from a rickety tap. No soap! I was next shown to the lying-in chamber, and in the obscurity walked in to the end of the bedstead, and had to back out again to allow the husband to get out, before I could get in. There, on a dirty bedding, lay the mother gazing through the one dirty window on a huge pile of old iron and general junk which represented the fruits of her husband's industry. She had a high temperature. I insisted on her removal to the hospital, and gained my point after some argument. It was not necessary to do anything for her, beyond reducing her to a state of approximate cleanliness.⁹²

Whatever McIlwraith's merits as a physician to this poor immigrant family, his voice here was that of the middle-class reformer. Sociologist Marianna Valverde has demonstrated how class, race and gender biases were articulated through language in early twentieth-century Canada.⁹³ McIlwraith's language was full of class expectations. "Low-browed", "greasy" and "filthy", were used to depict the surroundings; but they also served to make value judgements about the family. They betrayed the physician's attitude towards this "bearded" family, and the low level of esteem he accorded to the "general junk" which constitutes the husband's livelihood. Though the writer had little real knowledge of this working class family, his tone exuded disgust. All the patient needed, he felt, was to be removed and "reduced to approximate cleanliness". In McIlwraith's assessment, the hospital's main value was to save the patient from her working-class home.

⁹² McIlwraith, "Obstetrics and the State," 312.

⁹³ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland and Stewart, 1991, 11.

However, middle-class and wealthy child-bearing women were not excluded from medical value judgments. Many physicians felt that women of 'breeding', as a result of civilization, were particularly ill-equipped to withstand the rigours of labour. Historian Judith Leavitt has argued that this perception was grounded in social biases rather than in empirical evidence. "Upper-class women might well have been at risk because of atrophied muscles caused by tight corsets, inactivity, and a low-protein diet". However, "[w]orking-class women carried their own burdens of insufficient diet, physical overwork, stress, poor housing, and polluted milk and water."⁹⁴ In fact, maternal mortality rates reveal that working-class women were more likely to succumb to childbirth than their wealthier counterparts.⁹⁵ Nonetheless, physicians maintained an attitude towards their female patients which reinforced perceptions of delicacy in relation to women of wealthier families. "The necessity for relief in the majority of parturitions is urgent, especially among women in a high state of civilization as it exists to-day," wrote Gordon Copeland in the *Journal*.

Among the high-strung nervous women, in cities particularly, labour is frequently pathological. They are not sufficiently supplied by nature with those factors which enable women in savage states and of strong muscular development to deliver themselves without much trouble.⁹⁶

⁹⁴ Leavitt, *Brought to Bed*, 85-86.

⁹⁵ Leavitt, *Brought to Bed*, 72-73

⁹⁶ Gordon G. Copeland, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics", *CMAJ* 7:5, 1917, 405.

The following belief prevailed among medical professionals: female physical and mental health was dominated by the reproductive system; therefore, women were more vulnerable to illness because of the very nature of their bodies.⁹⁷ Modernity constituted an additional risk factor for female health. Education, exercise, and the quickened pace of industrial society overstimulated the female constitution. Birth could further tax a weakened female system. To ensure a safe delivery, appropriate medical assistance was required. The issue of degeneration caused by over-civilization gave physicians an opportunity to turn birth into a pathology which demanded their expertise. Thus, women's presumed increased susceptibility to illness, traceable to their reproductive systems, was linked to the after-effects of modernity. Industrialization and urbanization had significantly altered lifestyles over a relatively short span of time. Physicians blamed modern lifestyle for the poor health of individuals.⁹⁸

Even when the medical community considered women's physical health to be sufficiently robust, it questioned women's mental and emotional capacities. "The modern young woman does not possess the courage, endurance, and hardihood with which her mother and grandmother were endowed," wrote O. Bjornson in a 1925 volume of the *Journal*. "Physically she is perhaps just as well developed . . . but she approaches her

⁹⁷ Mitchinson, *The Nature of their Bodies*, 49.

⁹⁸ Anita Clair Fellman and Michael Fellman. *Making Sense of Self: Medical Advice Literature in Late Nineteenth Century America*. Philadelphia: University of Philadelphia Press, 1981, 46.

confinement in an altogether different frame of mind."⁹⁹ According to this medical hypothesis, modern women were more susceptible to pain and discomfort than were their elders. Again, the conclusion was that they required a physician's skills and talents to endure labour. This conceptualization converted pregnancy into a pathology.

The pathological interpretation of pregnancy was not unique to the rhetoric of medical professionals. After all, the high maternal mortality rate was evidence enough of the inherent dangers in pregnancy and confinement (see Appendix One). But in them it received its fullest and most sophisticated expression. In her study of childbearing on the western frontier in the nineteenth century, Sylvia Hoffert has argued that pregnant Anglo-Saxon women, often suffering from depression related to anxiety, poor health and fatigue, tended to view confinement as an illness. Increasingly, middle and upper-class women designated parturition by the term "sickness" or "illness".¹⁰⁰ Cognizant of the potential risks in pregnancy and probably sharing the cultural and class beliefs of their medical attendants, these women genuinely feared confinement and distrusted the capacities of their bodies to withstand multiple births over the course of their childbearing years.

In Canada, concerns for the ill-health of the general population were prevalent in discussions about the high maternal and infant mortality rates which hovered at 4.7 per

⁹⁹ O. Bjornson, "An Obstetrical Retrospect", *CMAJ* 15, 1925, 1238.

¹⁰⁰ Sylvia Hoffert, "Childbearing on the Trans-Mississippi Frontier, 1830-1900", *Western Historical Quarterly* 22:3, 1991, 276-77.

1000 live births in 1921.¹⁰¹ The issue gained particular prominence in the aftermath of World War I. During the war, recruitment drives brought it a countless number of young men whose health problems eliminated them from military service. In 1920, the president of the Manitoba Medical Association, in his annual address, cited dreadful statistics pertaining to recruitment:

For purposes of war, we have taken an inventory of our physical assets, and the results have been amazing. From 50 per cent to 75 per cent of our volunteers, draftees and conscripts have been found physically unfit for military service, and these for the most part have been the victims of preventable and curable diseases and physical defects.¹⁰²

The rejection as unfit for active duty of such a high proportion of potential recruits, had cast a shadow over the presumed good general health of the Canadian population.¹⁰³ Social reformers began targeting parents, especially mothers, in a bid to improve the health of Canadians.

In response to the national health concerns emanating from recruitment campaigns, physicians pointed to the high infant mortality rates, and the consequent high losses to the population. Medical professionals stressed the importance of prenatal care and physician attendance at births. Noted H.W. Hill: "From the point of view of race both stillbirths and miscarriages are of great importance, indicating as they do potential

¹⁰¹ Cited in F. H. Leacy, ed. *Historical Statistics of Canada*, 2nd edition. Ottawa: Statistics Canada, 1983, B51-58.

¹⁰² G. B. Shortreed, "Abstract of Presidential Address," *CMAJ*, X:3, 1920, 214.

¹⁰³ David C. Naylor, *Private Practice*, 35. See also Cynthia R. Abeele, "'The Infant Soldier': The Great War and the Medical Campaign for Child Welfare," *Canadian Bulletin of Medical History*, 5, 1988, 99-119.

citizenship lost to the population."¹⁰⁴ From infant and child welfare, it was but a short ideological step, along the path of reform rhetoric, to mothers.¹⁰⁵ Hill concluded:

Because two-thirds of the total loss of infant life . . . is due to prenatal or natal causes . . . the medical profession as a whole, all interested citizens, and the public generally should direct their attention especially to the physical condition of women preceding the prospective births of their children - particularly with regard to disease, nutrition and heredity in the broadest sense of those terms.¹⁰⁶

Thus, mothers were not targeted on their own; rather, they were intermediaries in child welfare initiatives. Similarly, Nathanson contended: "[I]f the unborn child is to survive, and not contribute to the existing excessive rate of infant mortality, the prospective mother must first be brought to the highest possible degree of physical efficiency during her pregnancy."¹⁰⁷ An attendant concern was that of a declining birth rate among middle-class English-speaking women. Some feared race suicide as a result of the combined effects of maternal mortality and the falling birth rate. The mother's role was being reduced to that of baby carrier by both medical profession and society alike. Her role as a person was marginalized to her role in fertility.¹⁰⁸

¹⁰⁴ H. W. Hill, "Prenatal Negligence and Loss of Population," *CMAJ* 11, 1921, 615.

¹⁰⁵ See Buckley, "Ladies or Midwives?," 133.

¹⁰⁶ Hill, "Prenatal Negligence", 618.

¹⁰⁷ Nathanson, "Prophylaxis in Obstetrics", 494.

¹⁰⁸ McLaren and McLaren, *The Bedroom and the State*, 17. See also Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*. Toronto: McClelland and Stewart, 1990, 22.

Alarm over the high infant and maternal mortality rates contributed to certain distortions as social stereotypes infiltrated medical diagnosis and interpretation. In his study examining the need for pre-natal care benefits in health insurance packages, Joseph Nathanson noted that among the near female relatives of insurance applicants, death rates from childbirth almost equalled those from tuberculosis and cancer combined.¹⁰⁹ In fact, as has been shown in the previous pages, tuberculosis, not childbirth, was the primary killer of women in turn-of-the-century Canada.¹¹⁰ Deaths from childbirth were no more common than female deaths from certain other causes, including accidents (though accidental deaths were far more prevalent among men than among women). However, no other major cause of death was uniquely gender-based. This accentuated the impact of maternal death rate statistics and discoloured their interpretation.¹¹¹ The maternal mortality rates exacerbated medical conclusions about the frailty of women and reinforced commonly held gender stereotypes.

No physician decried the death toll exacted by parturition more vociferously than did Helen MacMurchy, the director of the federal Public Health Department's Child Welfare Division. MacMurchy blamed as the primary contributor to maternal deaths the

¹⁰⁹ Nathanson, "Prophylaxis in Obstetrics", 1924, 494.

¹¹⁰ See pages 72 and 90 of this chapter. Also, see Katy Dawley, "Ideology and Self-Interest: Nursing, Medicine, and the Elimination of the Midwife," *Nursing History Review* 9 (2001), 101.

¹¹¹ Mitchinson, *The Nature of Their Bodies*, 55.

absence of appropriate care *of any sort*.¹¹² "[I]n addition to the great need of better medical and nursing care, pre-natal, obstetrical and post-natal," MacMurchy concluded in an article which outlined the findings of a national maternal mortality study, "the difficulty, often the impossibility, of getting any help in the house even during the first ten days after the birth of the baby is a cause for maternal morbidity and mortality in Canada."¹¹³

Though MacMurchy pointed to lack of general assistance in the home as a cause of maternal morbidity, most medical literature in Canada emphasized only technical and professional deficiencies. W.B. Hendry, writing in the *Journal*, maintained that lack of adequate professional and technical assistance was the central contributor to maternal deaths:

Consideration of the results leads one to the inevitable conclusion that in many cases there have been lack of supervision during gestation, careless preliminary examinations or none at all, ill-timed and meddlesome interference, imperfect technique and an unrecognized disproportion between mother and child.¹¹⁴

In Hendry's conclusions, as in much of the medical literature, the social and economic circumstances surrounding the mother and the birth were ignored. The birth attendant, rather than the mother, was the central figure.

¹¹² See Dianne Dodd, "Advice to Parents: The Blue Books, Helen MacMurchy, and the Federal Department of Health, 1920-1934", *Canadian Bulletin of the History of Medicine*, 8, 1991, 203-230.

¹¹³ Helen MacMurchy, "On Maternal Mortality in Canada", *CMAJ* 15, 1925, 296.

¹¹⁴ Hendry, "Maternal Mortality", 1923, 253.

Ironically, the statistics did not necessarily support physicians' contentions that the presence of a medical accoucheur would have saved maternal lives. In her study of maternal mortality rates, Helen MacMurchy referred to the absence of medical facilities in rural areas as a contributor to the sufferings of Canadian mothers. She quoted at length a Member of Parliament from North Battleford who noted of his riding :

There is no doctor living in this whole area. The nearest doctors available in cases of great need live in the towns along the lines of railway to the south and west a distance of thirty to seventy miles. The same applies to hospital provision. . . Owing to the amount of distress and suffering that exists the costs of obtaining medical advice, in most cases running from \$30.00 to \$70.00 a visit, it is only in extreme cases that medical aid is brought in and when the trouble occurs in the winter months the suffering is increased tenfold.¹¹⁵

Yet MacMurchy's data show that the death toll per 1000 births was higher in urban areas than in rural communities. Thus, proximity to physicians did not necessarily translate into safer births. Such statistics did not support physicians' contentions that access to professional services would lessen the maternal mortality rate.¹¹⁶

¹¹⁵ MacMurchy, "On Maternal Mortality", 1925, 293. According to MacMurchy's own statistics for 1922, the rural rate for maternal deaths was 4.4 per 1000 live births, while the urban rate was 6.7 (see page 294).

¹¹⁶ Admittedly, it is difficult to make a direct comparison between urban and rural statistics. In a study of infant mortality at the Toronto General Hospital from 1918 to 1922, W. G. Crosbie remarked that the percentage of abnormal cases, and thus the mortality rate, would be higher in hospitals where a considerable number of complicated cases were sent, often after the onset of labour. W. G. Crosbie, "The Obstetrical Causes and Prevention of Stillbirth and Early Infant Mortality", *CMAJ* 13, 1923, 877.

In a later study, MacMurchy continued to draw the attention of her colleagues to mortality rates associated with pregnancy.¹¹⁷ Speaking as a physician, rather than as a woman or an advocate for women, she called for improved aseptic conditions and the need for society to "regard pregnancy as a condition requiring medical supervision."¹¹⁸ Despite the findings of her own study, which attributed many maternal deaths to poverty, general poor health and exhaustion from domestic chores, MacMurchy remained faithful to her professional party line.¹¹⁹ Probably unwittingly, MacMurchy and other female health care personnel acted as a bridge between the traditional community of women attending parturient women and the world of modern medicine.

While there can be no question that doctors increasingly involved themselves in confinement cases, the extent of their usefulness to women remains a debatable issue. Professionals, themselves, recognized the potential harm they could induce by inappropriate intervention. The injudicious use of instruments and intrusive manipulation could create dangerous complications for mother and infant which could be fatal. Notwithstanding the potential for complications resulting from their interferences, physicians were equally critical of colleagues who jeopardized mother and baby, they

¹¹⁷ Helen MacMurchy, "Maternal Mortality in Canada," *CMAJ* 19, 1928, 1434-37.

¹¹⁸ Suzann Buckley, "The Search for the Decline in Maternal Mortality: The Place of Medical Records", in *Essays in History of Canadian Medicine*, Wendy Mitchinson and Janice Dickson McGinnis, eds. Toronto: McClelland and Stewart, 1988, 154.

¹¹⁹ Buckley, "The Search for the Decline in Maternal Mortality," 153.

felt, by failing to be proactive. The question of finding the appropriate balance was a matter of continuing discussion in the *Journal*, as Nathanson admitted:

Patience in obstetrics is next to asepsis, but it must be the active patience of close observation; not the passive patience of ignorance, allowing the mother to become totally exhausted, or the baby in imminent peril of death before determining on a line of action.¹²⁰

The question of when to intervene was a judgement call for the physician, whose medical knowledge and scientific training often disguised a lack of actual experience with childbirth.

Physicians writing in the *Journal* lamented the paucity of obstetric education, noting that most physicians were simply unprepared for childbirth attendance. "The physician in many cases overestimates his own abilities, and does not recognize the limitations of his knowledge, or the extent of his qualifications," remarked Nathanson. "At the same time, the responsibility which he owes the prospective mother and her child is very much underestimated."¹²¹ Robert Ferguson, Professor of Obstetrics and Gynecology at the University of Western Ontario, argued that "the average medical attendant presumes to trust to nature so far that when he encounters some abnormal condition he is incompetent to recognize or cope with the difficulty."¹²² Ferguson further maintained that young physicians were not being instructed in adequate obstetrical techniques:

¹²⁰ Nathanson, "Prophylaxis in Obstetrics", 495.

¹²¹ Nathanson, "Prophylaxis in Obstetrics", 495-6.

¹²² Robert Ferguson, "A Plea for Better Obstetrics", *CMAJ* 10, 1920, 902.

Unless the practitioner has acquired in his student course, a knowledge of the mechanism of labour in its various presentations and positions, normal and abnormal, he will never master its technique in the busy routine of actual practice and consequently he can never be relied upon to give competent and expert service in the emergencies and difficulties of obstetrics practice.¹²³

Though Ferguson warned of the dangers of incompetent physicians, not once did he question the place of doctors in the birthing room. Physician involvement went unexamined. Only medical techniques were faulted, not participation of the physician himself. "Techniques must be simple, must be adequate, and, among the poor, inexpensive," wrote W.W. Chipman in the *Journal*. "One of the dangers of hospital technique," he continued, "is that it tends to be too elaborate, and too far-removed from the possibilities of private practice."¹²⁴

In addition to professional education, physicians endorsed increased maternal education through public health initiatives. Historian Denyse Baillargeon has shown that women, especially those from the working-class, were not always eager to accept the advice of physicians. As a result, feminist middle-class reformers collaborated with public health professionals on educational campaigns designed to inform women about the medically prescribed scientific maternal care.¹²⁵ Nathanson, a proponent of this tactic, maintained:

¹²³ Ferguson, "A Pleas for Better Obstetrics", 902.

¹²⁴ W. W. Chipman, "Problems of Obstetrical Practice", *CMAJ* 8:6, 1923, 381.

¹²⁵ Denyse Baillargeon, "Care of Mothers and Infants in Montreal between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de Lait, and Assistance Maternelle", in Dodd and Gorham, eds., *Caring and Curing*, 164-65, 178

The public must be taken into the confidence of the medical profession, and taught in a practical manner how much can really be accomplished by proper pre-natal care, and by the practice of clean obstetrics associated with reasonable skill, for as Pomeroy has aptly put it, too many women of all classes "select their obstetricians as they select their bridesmaids."¹²⁶

Accordingly, physicians were involved in shaping and managing expectations. This allowed the profession to prescribe patient needs indirectly and to ensure a market for its services.

Nathanson articulated the profession's attitude:

It has become very evident that much can be gained through the exercise of sympathetic tact; and once having won the patient's confidence, the value of pre-natal care to herself as well as her unborn child, can easily be brought out, and having accomplished this, the patient invariably shows a desire for co-operation even beyond our most sanguine expectations.¹²⁷

The assumption was that women simply did not understand how much they required physician services. However, once grasping the benefits, they would surely perceive the error of their ways and seek remedy in the form of professional parturient attendance. Patients acquiesced in the medical assumption, less for the sake of the profession and its claims than for the sake of the prospect of safer and less painful childbirth experiences. And physicians maintained that the course of safety was best served by medical instruction and interventions, despite acknowledging their inadequate training and experience. This steadfast assurance of its importance may have been a reaction to the profession's actual precarious identity in the birthing room process. Largely self-invited

¹²⁶ Nathanson, "Prophylaxis in Obstetrics", 495.

¹²⁷ Nathanson, "Prophylaxis in Obstetrics", 495.

to the birthing rooms of the 1910's and 1920's, physicians did not yet have control of procedures and decisions.¹²⁸ As a result, their roles were tenuous. This prevented them from prescribing what they considered to be the most efficacious course of action for mother and child.

Though fewer advances had been made in obstetrics than in other branches of medicine, medical knowledge still offered physicians certain advantages.¹²⁹ "As compared with the sister subjects of medicine and surgery," wrote Chipman, "obstetrics has rather been, not a first, but a last consideration."¹³⁰ Nonetheless, the 'sister subjects' indirectly influenced obstetrical practices, and provided tangible arguments for the presence of physicians in the birthing room.

Surgery provided one source of legitimacy for the presence of physicians. Even better for physicians, it made available a skill to which irregular birth practitioners could not lay claim. Only those with professional training could wield the scalpel. Surgical advances raised the profile of the medical man while diminishing the stature of traditional service providers. "An obstetrician is, by virtue of his office, a surgeon," remarked Toronto physician K. C. McIlwraith in the *Journal*.¹³¹ Though understanding the principals of pregnancy and birth was nascent and elusive, the application of rigid

¹²⁸ Leavitt, *Brought to Bed*, 139.

¹²⁹ Swartzlander, "The Medical Treatment", 222.

¹³⁰ Chipman, "Problems of Obstetrical Practice", 1923, 379.

¹³¹ McIlwraith, "Obstetrics and the State", 309.

surgical techniques to the process of childbirth placed physicians in control. It allowed them to make an important link between parturition and the hospital process. It also allowed them to link the physiology of parturition with general physiology and anatomy in which they were the expert. W. W. Chipman wrote in the *Journal*:

Parturition is a physiological process, identical in the countess and in the cow. At least, until recently, it has been so regarded. Physiological the process is, and yet as regards the countess - and every mother is a countess - this natural process still remains a hazardous occupation.

The language was not particularly flattering, but the implicit notion was clear. Childbirth was an inherently dangerous process for mothers, as indicated by high mortality statistics. But it was also a physiological process. Physicians saw themselves as the experts in physiological processes. Therefore, physician attendance was a necessity in the birth process.

It was through the exceptional case, the threat of extenuating circumstances, that the physician most directly connected birth and medical expertise. The Caesarian section, for example, represented a bridge between traditional delivery and medicalized surgery.¹³² Named after its most famous beneficiary, Julius Caesar, caesarian section had been around for centuries but had fallen into disuse due to its usually fatal outcome. Revived in 1882 by a German physician, Max Sanger, using aseptic methods and silk suturing of the uterine wall, caesarian section had become a safer means of delivery than it had

¹³² "Caesarian section" is defined as "delivery of the fetus by incision through the abdominal and uterine wall" in Leavitt, *Brought to Bed*, 272.

previously been.¹³³ Appropriately used, it afforded opportunity to circumvent complications associated with vaginal manipulation and pelvic deformity.

In 1913, Frederick Fenton outlined procedures for Caesarian section in the *Journal*. After thoroughly scrubbing and sterilizing the skin, a four inch incision was to be made to the right of the mid-line, the centre of the wound opposite the umbilicus. The uterus was to be opened, and the child removed by grasping one leg. The placenta and membranes were then to be delivered through the abdominal wound, following which the uterus was to be manually compressed before being sutured and returned to the abdominal cavity.¹³⁴ Accordingly, the process of birth was to be a fully medicalized experience, the patient reduced to a uterus and abdominal cavity and the procedure conducted without her mental presence. Each birth was seen as a standard, mechanical, physical function requiring a standard, mechanical, physical technique. But the exceptional case invited exceptional techniques. Caesarian section was an exceptional technique. Its increasing use was justified by potential complications which could arise in the standard process. Early indications for caesarian section included placenta praevia and contracted pelvis. By the 1920s, however, caesarian section was conducted for a myriad of reasons:

At the present time the indications for Caesarian Section . . . embrace the following conditions, namely, tumours, impacted shoulder presentation, abnormal conditions of the child, undue rigidity of the cervix and vagina,

¹³³ Wertz and Wertz, *Lying-In*, 139.

¹³⁴ Frederick Fenton, "Report of a Series of Abdominal Caesarian Sections", *CMAJ* 3:10, 1913, 842-43.

grave diseases threatening the life of the mother and some cases of prolapse of the cord.¹³⁵

It was this potential for difficulties in the process which warranted a place in the birthing room to the physician skilled in surgical techniques.

The issue of asepsis also connected surgery with obstetrics. Medicine's demands for sterile birthing conditions aligned the parturient process with medical procedure. To achieve absolute cleanliness, more was required than a few clean sheets and hot water. Sterile conditions could be effected only by adherence to strict procedural guidelines. Fear of puerperal infection catapulted physicians to authoritative stature. Physicians not only claimed that they knew; they began also to be presumed to know. In a supplement to the *Canadian Mother's Book*, MacMurchy emphasized the need for cleanliness in the birthing-chamber:

BE Clean. Take off your dress. Scrub your hands and arms clean with soap and hot water. Put on a clean wash dress and apron. Roll up the sleeves over your elbows, scrub your hands and arms again and clean your nails. Scald, scrub and clean THOROUGHLY all the pitchers, basins and dishes you need. Put on plenty of water to boil.¹³⁶

These procedures were methodological in nature. Practically speaking, they required that the attendant be instructed in proper technique. By implication, only physicians could provide such instruction. Moreover, physicians continually angled for births to occur only within environmentally-controlled areas. "The best nurse we can get and the best

¹³⁵ A. Mackinnon, "Caesarian Section", *CMAJ*, 12, 1922, 405.

¹³⁶ Helen MacMurchy, *The Canadian Mother's Book Supplement*. The Little Blue Books Mother's Series. Ottawa: F.A. Acland, 1923, 144.

doctor we can get are needed when the baby comes", noted *The Canadian Mother's Book*. "We should think of this when we build our Canadian home."¹³⁷ The implication was that women setting up a home and housekeeping should consider their location in terms of its proximity to appropriate medical attendance and medical facilities.

Curiously, despite widespread acceptance by the 1920's of aseptic childbirth, many physicians continued to neglect the strict antiseptic regimen. As noted by McIlwraith in 1920:

Many men, doing obstetric work in hospitals fail, I am afraid, to realize the value of the precautions by which their work is there surrounded. The aseptic delivery room, sterilized water, solutions, dressings, instruments and ligatures; the preparation of the patient for delivery, the gloves, gowns, caps and masks, with which they are supplied, are taken for granted, laughed at or even refused.¹³⁸

Many physicians simply did not link the need for asepsis with childbirth; they refused to believe that puerperal infection could be a product of their own contamination.

Eventually, however, the concept of asepsis came to dominate birthing procedures. It provided a primary justification for the removal of confinement patients to hospitals.

Surgery was not the only means by which physicians gained access and stature in the birthing room. Medicinal discoveries provided another vehicle. Initially, some physicians were reluctant to make use of anaesthesia in the birthing room. They feared that alleviation of labour pains would retard the birth process. If the pain accompanying uterine contractions were unavailable as a stimulus, mothers would not efficiently 'bear

¹³⁷ MacMurchy, *The Canadian Mother's Book*, 139.

¹³⁸ McIlwraith, "Obstetrics and the State," 309.

down' to expel the baby. Ultimately however, "both physicians and women developed the perceptions that birth events were not fated but could be shaped in large part by planning and making use of medical advances".¹³⁹ These included anaesthesia, analgesics, anti-coagulants, coagulants, and operative instruments - anything conducive to allaying fear and relieving pain. Medical journals soon teemed with discussions on the appropriate use of medication. But the two leading issues debated in the *Journal* concerned the use of pituitary extract (Piturin) and the administration of medications to bring about "twilight sleep".

In 1909, the British physician Blair Bell had introduced pituitary extract into obstetrics as a means of inducing uterine contractions and stimulating birth. Writing in the *Journal*, B. P. Watson stated, "[W]hen administered to a woman in labour the extract quickly causes an increase in the strength of the uterine contractions, while the duration of contraction becomes prolonged and the intervals between pains shortened."¹⁴⁰ Thus, by affording some control over uterine contractions, pituitary extract provided physicians with some control over the birth process. By the early 1910s, pituitary extract was a standard prescription in physician-assisted births. "It was politely, but none the less decidedly, inferred," wrote Ross Mitchell in 1921, "that the great majority of the obstetric physicians who had not yet bowed to the knee of this new Baal were old fogies."¹⁴¹

¹³⁹ Leavitt, *Brought to Bed*, 199.

¹⁴⁰ B. P. Watson, "Pituitary Extract in Obstetrical Practice", *CMAJ*, 3:9, 1913, 741.

¹⁴¹ Ross Mitchell, "The Use of Pituitary Extract and Scopolamine-Morphine in Obstetrics", *CMAJ* 11, 1921, 351.

Due to its beneficial properties and flexible applicability to the several stages of labour, pituitary extract was quickly adopted. In 1917, Harry Swartzlander, a small town Alberta physician, wrote that piturin has been one of the main medical advances in the past ten years.¹⁴² Even obstetricians at prominent and prestigious Canadian hospitals remarked on the speed with which its use had spread throughout Canada. "It seldom happens that a new drug or remedy comes into universal use in such a short space of time," commented Watson, an obstetrician at the Toronto General Hospital.¹⁴³ Pituitary extract could accelerate and render more easily predictable the labour process. Firstly, when the mother was not in labour, but labour was desired, pituitary extract could induce it. Secondly, pituitary extract could be used in the first or second stages of labour to strengthen weak contractions and speed up the process. Thirdly, pituitary extract could be used after the birth (the third stage of labour) as a means to control uterine haemorrhage or assist the expulsion of the placenta.¹⁴⁴

However, sustained high maternal mortality rates led to accusations of piturin abuse by professionals. "Probably the most frequent and pernicious or criminal error is the injurious or routine use of pituitary extract", wrote Winnipeg obstetrician O. Bjornson in 1925.¹⁴⁵ Manifesting a Jekyll and Hyde attitude, the profession heralded pituitary

¹⁴² Harry Swartzlander, "The Medical Treatment of the Obstetric Cases", *CMAJ*, 7, 1917, 224.

¹⁴³ B.P. Watson, "Pituitary Extract in Obstetrical Practice", 739.

¹⁴⁴ Watson, "Pituitary Extract in Obstetrical Practice", 743-754.

¹⁴⁵ Bjornson, "An Obstetrical Retrospect", 1237.

extract as an advance, but condemned the physician too reliant on its properties.

Individual practitioners were left to decipher the rhetoric and use appropriate judgment.

In the context of 'Twilight Sleep', introduced to North America in the 1910s, the profession again was accused of abuse - this time with respect to obstetrical anaesthesia. The debates concerning Twilight Sleep were heavily influenced by the demands of patients, unlike most medical controversies, which are ordinarily consigned to professional debates in medical journals.¹⁴⁶

Twilight Sleep involved the administration of amnesiac and anaesthetic drugs during labour so that a mother would have a healthy baby, but no memory of the birth experience. It had been initially developed in Germany in 1907 by Drs. Kronig and Gaus of the Freiburg Clinic. By 1914, it had become a contested issue in North America.

Physicians relented to consumer demand for the scopolamine-morphine mixture.

Following a patient's inquiry regarding Twilight Sleep, Bjornson lamented in the

Journal:

For weeks and months before her confinement, she has heard whisperings of twilight sleep, chloroform, ether and nitrous oxide, and how Mrs. So and So was given an anaesthetic and her baby taken away. Therefore after a variable time in labour she declares that she can stand this no longer, and firmly demands that she be given something at once.¹⁴⁷

For many women, twilight sleep promised a perfect solution to the *problem* of confinement.

¹⁴⁶ See Judith Walzer Leavitt, "Birthing and Anaesthesia: The Debate over Twilight Sleep", *Signs*, 6, 1980-81, 147-164.

¹⁴⁷ Bjornson, "An Obstetrical Retrospective", 1238.

The Twilight Sleep procedure involved administration of a combination of drugs and the provision of a relaxing environment. The aim was to induce an amnesic semi-conscious state. Ideally, the patient would be freed of any memory of the event. A Winnipeg physician, Ross Mitchell, described the technique for twilight sleep as it was used in Canada:

When labour has clearly begun, the woman is removed to a darkened private room. Cotton wool is placed in her ears, dark spectacles over her eyes and great care is taken to avoid as far as possible external stimuli. An initial dose of 1-6 grain morphine or the equivalent of narcophen with 1-150 to 1-200 grain of scopolamine is given. Thereafter, various memory tests are applied, the idea being to keep the patient in a state of amnesia In successful cases the patient passes into a somewhat somnolent condition with flushed face, injected eyes and an accelerated pulse rate and sleeps quietly in the interval between pains but complains bitterly during their continuance After delivery the child is removed from the room and on being wakened at the end of three or four hours, the patient is usually surprised to learn that her baby has been born.¹⁴⁸

The expense of the technique limited its availability to all but the wealthier classes. Moreover, not all women were susceptible to its hypnotic effect. In most cases, the desirable ideal conditions could not be reproduced. Mitchell noted that the primary factor in the success of Twilight Sleep was the element of suggestion. At the Freidberg Clinic, physicians believed that the procedure was better suited to upper-class women "who respond to the stimulus of severe pain . . . with nervous exhaustion and paralysis of the will to carry labour to conclusion."¹⁴⁹

¹⁴⁸ Ross Mitchell, "The Use of Pituitary Extract", 352-53.

¹⁴⁹ Cited in Leavitt, *Brought to Bed*, 130.

In the United States, through the Twilight Sleep Association, women lobbied the medical profession to adopt the German technique. The medical community's impression of the procedure was divided. Some claimed the technique was too dangerous; others vouched for its safety and reliability.¹⁵⁰ In an 1915 editorial, the *Journal* warned of propaganda from the lay press:

Very unfortunately a year ago Twilight Sleep fell . . . into the columns of the lay press. Therein it was heralded as one of the world's greatest discoveries - a universal anodyne in child-birth. Newspapers and periodicals vied with each other in the exploitation of its virtues, and before the war there was no subject of such universal interest.¹⁵¹

The promise of painless parturition threatened the authority of physicians. In the first place, physicians could not provide, at least on a consistent basis, the painless experience women considered Twilight Sleep to be. Furthermore, upper-class women were demanding a commodity which the profession at large had not yet adopted. Since the profession could not provide what women expected and considered to be available, doctors' control over the birth-market was jeopardized.

In Canada, the campaign for twilight sleep did not achieve the same level of organization it did in the United States. However, the issue did creep into popular magazines, allowing for considerable public debate well beyond the purview and control of physicians. Francis Marion Beynon, an outspoken writer for the *Grain Growers Guide*, jumped into the fray:

¹⁵⁰ Leavitt, *Brought to Bed*, 134-35.

¹⁵¹ "Editorial", *CMAJ* 5, 1915, 807.

It is not the mere dread of the agony of birth which daunts our women, it is also that they know of the after-exhaustion and sometimes chronic illness which follows so-called "normal" births. It has been proved conclusively that the exhaustion is due not solely to the shock to the body, but to the psychic and mental shock caused principally by fear. Yet every doctor who had conscientiously administered twilight sleep comments on the total absence of nervous exhaustion in the mother after the birth when this method is used.¹⁵²

Beynon's support for Twilight Sleep exemplifies the importunity of women when faced with the possibility of confinements having lasting debilitating effects. Without access to effective birth control methods, women of the period felt fearful of pregnancy and its potential serious medical sequelae. They panicked over the pending pain of childbirth. Female fears received expression in the public controversy over Twilight Sleep.

Many physicians were steadfast in their opposition to Twilight Sleep. They refused to acquiesce to the procedure's popularity. Swartzlander warned of the bad effects of the scopolamine-morphine mix. For example, it could interfere with pituitrin. Such complications undermined the difficult effort to achieve the right atmosphere for the beneficial application of the procedure.¹⁵³

Canadian physicians mirrored their American brethren's reluctance to embrace Twilight Sleep whole-heartedly. In a 1916 *Journal* article which examined fifty-two cases of the application of Twilight Sleep, three Montreal obstetricians concluded that the technique's methodology was still in its infancy. Though further research on its

¹⁵² Francis Marion Beynon, "The Country Homemakers - Painless Childbirth", *Grain Growers Guide*, September 19, 1916, 9.

¹⁵³ Swartzlander, "The Medical Treatment of Obstetrical Cases", 223.

development was indicated, they could not endorse its wide-spread application. They noted that each case had to be considered individually. For a successful outcome, the full attention of the treater was required.¹⁵⁴

Two great control issues propelled the debates over twilight sleep - the issue of pain control and the issue of women having control over the birth process. Women feared the pain and potential debility of delivery. They demanded that the pain relief methods be made available. Anaesthesia held out the promise of pain control. Ironically, many physicians were reluctant to use scopolamine in parturition because they perceived it would interfere with a normal bodily process. "When we reflect that we are dealing with a perfectly healthy individual, and an organ engaged in a purely physiological function," noted one American physician, "I fail to see the necessity of instituting such a measure in normal labour."¹⁵⁵ In this professional about-face, the naturalness of the birth process was being emphasized. The medicalization of childbirth, and medicalized discourse, were being expelled in order to combat a medical technique unsanctioned by the North American professional organizations.

An even greater irony is discernible in the issue of control over birthing practices. As Leavitt argues: "Although women were out of control during twilight sleep deliveries ... the loss of physical control was less important to them than their determination to

¹⁵⁴ J. W. Duncan, Charles Holbrooke, and George W. Phelan, "Twilight Sleep", *CMAJ* 6:2, 1916, 108-109.

¹⁵⁵ Cited in Leavitt, *Brought to Bed*, 136.

control the decision about what kind of labour and delivery they would have."¹⁵⁶ In apparent contradiction with concerns of late twentieth-century feminists, women of the early decades of the twentieth century were willing to forsake physical control (and even consciousness) if this promised safer and less painful childbirth. Late Victorian women were prepared to give up physical control for the sake of controlling the overall birthing experience. Twilight Sleep was a symbol of women's efforts to control their birth experience. Women would give up one form of control to win another. The reward for women in gaining control of birthing practices was the promised release from pain and fear which Twilight Sleep could make available.

But as women aspired for control of birthing practices, so too did physicians crave for increased professional prestige and control. The Twilight Sleep technique served the yearnings of the latter in the following manner. The Twilight Sleep technique was sufficiently complex to support the contention that births should be removed to hospitals. It reinforced arguments based on the controlled conditions required for asepsis and the necessity to have readily at hand the availability of caesarian section. Ironically again, a technique which was never wholly embraced by the profession permitted the profession to assert even greater claims to expertise with respect to childbirth. The fact that the demand for Twilight Sleep was consumer driven highlighted even further the professional expertise available only through physicians.

¹⁵⁶ Leavitt, *Brought to Bed*, 136-37.

Thus, as women gained ground in controlling birthing practices, so too did physicians gain in authority and professional prestige. The result of the gains on both sides was that the period of gestation leading up to labour was a time during which patient and professional negotiated the terms of the physician's involvement in the birthing room.

The post-labour period was yet another matter. Here the main debate concerned the intervention versus non-intervention of the physician. Traditional practice called for manual extraction of the placenta or afterbirth, where necessary. Earliest concerns for the potential danger of this practice arose independently and almost simultaneously. The great American physician, Oliver Wendell Holmes, in 1843, and the Hungarian physician, Ignaz Philipp Semmelweis, in 1846, grounded their arguments in observational data. They claimed that doctors were exposing parturient patients to puerperal fever by way of manual extraction of the placenta. The medical community at large was reluctant to accept the notion that gentlemen-physicians could be carriers of contagion. As a result, many physicians, prior to attending maternity patients, refused to comply with prescribed aseptic hand washing directives.¹⁵⁷

By the 1910's, even after the notion of asepsis had taken root, the issue of intervention remained controversial enough to be the object of repeated warnings in the medical literature. In a 1914 *Journal* article, McGill University professor James R.

¹⁵⁷ Wertz and Wertz, 120-124. See also Carter, K. Caldwell and Barbara R. Carter, *Childbed Fever: A Scientific Biography of Ignaz Semmelweis*. London: Greenwood Press, 1994.

Goodall, maintained that "the proper course to adopt is to refrain from any form of treatment which entails invasion of the uterine cavity". "The real question", he concluded, "is not whether or not we should interfere and remove these products, but whether the dangers of interference are not greater than those of a policy of *laissez-faire*."¹⁵⁸ In fact, most physicians decried any manipulation of the uterus or its contents, though most also outlined exceptions to the general rule. However, few mentioned any preventative measures to lessen the chance of infection. Goodall was a case in point. Though probably an adherent of aseptic technique, he did not feel the necessity to mention it where "invasion of the uterine cavity" was attempted. He recommends neither that the birth attendant wash his hands, nor that he use rubber gloves, even though such a practices had been already commonly adopted. As late as 1923, W. W. Chipman steadfastly argued against post-partum intrusions, unless the patient had been admitted in the afterbirth period with suspicion of retained matter. In such a case, Chipman allowed for exploration of the uterus with one finger. He did not, however, mention the need to sterilize or cleanse the hands before proceeding.¹⁵⁹ It is possible that aseptic theory had become sufficiently established in the in the medical community that reiteration was unnecessary. However, physicians obviously continued to fear the danger of infection brought about by manipulation of the birth canal despite adherence to aseptic theory.

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¹⁵⁸ J. R. Goodall, "The Treatment of Puerperal Infections," *CMAJ*, 4, 1914, 590.

¹⁵⁹ W. W. Chipman, "Problems of Obstetrical Practice", *CMAJ*, 13:6, 1923, 386.

The medicalization of childbirth represented a long-term process involving a considerable degree of negotiation between mothers and physicians. Ultimately, physicians gained control of the birth experience. But the profession was plagued with a potentially embarrassing dichotomy. They had become experts in childbirth despite a general paucity of knowledge and limited educational curriculum in childbirth techniques. Part of their professional birth attendant status was self-acquired; but perhaps a larger part was imposed by women seeking safer and less painful birth experiences, and by a society seeking a scientific remedy to elevated infant and maternal mortality and morbidity rates. Of one mind in its desire to control the process of childbirth, the profession failed to provide clear guidance to individual physicians working in the obstetrical field. The general "party-line" was that it was up to the physician to make immediate and informed decisions on an individual case by case basis.

Debate centered around the physician's role during childbirth and the problem of maternal mortality. Medical literature rarely addressed the role of mothers. Medical authors provided theories and recommendations, but they characteristically omitted the patient from the process they studied. The result was medical patriarchy, part of the motivation for which was a genuine belief that medical principals could produce safer childbirths. Patriarchy was implicit in the "doctor knows best" mentality which infused birthing chambers, but in most cases, this was a sentiment mothers were willing to adopt. Why this female willingness? The answer is that women were eager to embrace whatever approaches promised to lessen the physical and mental torments that had become the legacy of the childbirth experience.

As the delicate balance between physician intervention and non-intervention shifted to and fro, the degree of marginalization of the patient remained a constant factor. In order to acquire control of events in the birthing chamber, physicians had to perceive maternity patients as mechanized medical model components. The process of birth was divided into stages that omitted the presence of the mother in favour of the progression of the foetus through the birth canal. The physician focussed on this progression. Pain and fear were distractions for both patient and physician. They threatened to obstruct, or interfere with, the birth process. As potential obstructions to normal birth, they needed to be eliminated through smooth management.

Pre-natal care, anaesthesia, and contagion theory were adopted by the medical community, sometimes with a sizeable push to do so from patients demanding access to modern medicine. The issue of control of birthing practice, and who was to possess it, had a different tone for turn of the century women than that to be found in late twentieth century feminist writing. Early twentieth century women considered the medical community's reluctance to use the tools of its trade, including anaesthetics and analgesics to allay the pain of childbirth, to be cruel and uncompassionate. They also construed this reluctance to limit women's control over their own childbirths. Though medicine offered patriarchy, the demands of women were for something very different.

Chapter 2, Appendix 1

**Maternal Mortality Rate, Stillbirth Rate, Infant Death Rate
(all per 1000 live births)
Canada 1921-1940**

	Maternal Mortality Rate	Stillbirths	Neo-natal Deaths	Infant Death Rate (under 1 year of age)
1921	4.7	34.3	43	102
1922	5.1	32.9	44	102
1923	5.0	34.1	44	103
1924	5.3	33.4	42	94
1925	4.9	32.8	41	93
1926	5.6	30.2	48	102
1927	5.5	31.0	45	95
1928	5.6	31.5	44	90
1929	5.7	31.9	44	93
1930	5.8	31.3	43	91
1931	5.1	31.5	42	86
1932	5.0	30.5	38	75
1933	5.0	30.4	37	74
1934	5.3	29.0	36	73
1935	4.9	28.8	35	72
1936	5.6	28.6	34	68
1937	4.9	28.2	34	77
1938	4.3	27.8	32	64
1939	4.3	27.4	31	61
1940	4.0	27.0	30	58

Source: F. H. Leacy, M. C. Urquhart and K. A. H. Buckley, eds. *Historical Statistics of Canada*, first edition. Ottawa: Statistics Canada, 1983, plate B1-14.

Chapter Three

Strychnine, Whiskey, Coffee and Saline: Birth at the Winnipeg General Hospital, 1880s to the 1920s

The Winnipeg General Hospital [the WGH], one of the largest teaching hospitals in the country at the turn of the twentieth century, was a product of its time in health care delivery. Programs and services at the WGH paralleled the evolution of the culture of professional medicine. Within hospital walls, physicians were crafting for medicine a new world, where dictums of scientific theory were secular gospel and physician authority dominated patient treatment. "If the hospital had been medicalized," notes medical historian Charles Rosenberg in reference to this period in medical history, "the medical profession had been hospitalized."¹ This was the atmosphere within which the fledgling specialty of obstetrics came into its own as a recognized medical discipline. Though physicians at this time had made inroads into the birthing chamber, their presence was not the norm in Canadian society. The statistics for physician attended births are often elusive. Ross Mitchell, chair of the Manitoba Medical Association's Maternal Mortality Committee, reported the proportion of physician-attended births to vary across provincial districts from 10% to 100%.² Typically, doctors attended the birthing rooms of

¹ Charles E. Rosenberg. *The Care of Strangers: The Rise of America's Hospital System*. N.Y.: Basic Books, 1987, 346. A similar idea is supported by S.E.D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament", *Journal of Canadian Studies*, 18:4, 2983-84, 7; and David Gagan. *A Necessity Among Us': The Owen Sound General and Marine Hospital, 1891-1985*. Toronto: University of Toronto Press, 1990.

² Ross Mitchell, "Report of the Maternal Mortality Committee of the Manitoba Medical Association", *Manitoba Medical Bulletin*, 1928, 7-8.

the poor in public hospital wards, the wealthy, and those with severe complications during birth. The hospital figured even less in the conventional birth experience, with most births occurring in the home. Until 1942, more than half of all births in Canada occurred outside the hospital.³

Through the hospital, however, physicians developed the aura of expertise that would further obstetrical practice. The emergence of hospitals as recognized centers of health care delivery contributed to the medicalization of births. In their earlier years, hospitals had been viewed as charitable institutions of desperation for the ailing poor. However, the coupling of science and medicine in the late eighteenth and early nineteenth centuries altered the reputations of medical institutions, and indirectly influenced health care.⁴ As hospitals acquired better reputations, they began slowly defining standards of medical care. A specialty such as maternity was an excellent candidate for hospital admission. However, the process that brought births into hospital was slow and mired by conflicting opinions both within the profession and in the public eye. Childbirth was eventually brought into the institutional fold. But this was possible only when physicians were able to convince women that safer and less painful births could be achieved in hospital.

Physicians were only beginning to learn about the mechanics of childbirth and the role their methods could play in maternity care in the late nineteenth century. While

³ See Appendix 1, Table I.

⁴ See Rosenberg, *Care of Strangers*, 338. See also G. Harvey Agnew, *Canadian Hospitals, 1920 to 1970: A Dramatic Half Century*. Toronto: University of Toronto Press, 1974, 2.

scientific research had identified the cause of puerperal fever, the only effective combatant known was preventative cleanliness and maintenance of a sterile environment. As a result, childbirth fever continued to claim the lives of many mothers. Before Sir Alexander Fleming's discovery of penicillin in 1928, doctors were unable to prescribe a cure.

The other great promise of late nineteenth and early twentieth century medicine, that of painless childbirth through the exercise of anaesthetic pharmaceuticals, was equally ambiguous. The use of drugs was an inexact science at best. The administration of ether and chloroform was largely guess-work, and the employment of narcotics during confinement raised further safety concerns.⁵

Relying on medical records from the Winnipeg General Hospital, this chapter will begin to shed some light on negotiations that eventuated in the hospitalization of childbirth. The experiences of women in WGH maternity wards were representative of the broader experience of women giving birth within hospital walls. Since most births in Canada between the 1890s and 1930s occurred outside the hospital environment, the records of the WGH do not reflect the general parturient experiences of Winnipeggers or Canadian women during this period. However, the institutional story offers insight into

⁵ Judith Walzer Leavitt. *Brought to Bed: Child-Bearing in America, 1750-1950*. N.Y.: Oxford University Press, 1986, 117. See also Wendy Mitchinson. *The Nature of Their Bodies: Women and Their Physicians in Victorian Canada*. Toronto: University of Toronto Press, 1991, 175-180; and Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939", in *British Columbia Reconsidered: Essays on Women*, Veronica Strong-Boag and Gillian Creese, eds. Vancouver: Press Gang Publishers, 1992, 146.

the new medical developments surrounding parturient care and the metamorphosis of childbirth attendance.

Generally, the acceptance of medical authority in health care delivery is relatively easy to understand. Firstly, physicians were members of an emerging professional class whose expert authority was shaping social ideals. As such, their voices were mingling with those of other professionals eager to create a society built on social reform, which also accorded a valued role to their particular expertise.⁶ Secondly, doctors provided a form of scientifically-based alternative in matters of illness and disability which the public was willing to receive. However, childbirth was not generally a matter of illness or disability, nor was it perceived as a social ill deserving of societal attention. Its shift from a traditional home-bound experience into an acute sickness relocated under the umbrella of the hospital is more difficult to comprehend.

The process by which physicians arrived at the bedsides of expectant mothers was the product of a complex, and not always overt, collaboration between the medical profession and women themselves. As discussed in the previous chapter, many early twentieth century female advocates of physician-centered birth techniques (such as Twilight Sleep) argued that, in choosing to admit physicians into the birthing room, women were in fact exerting control over their own medical experiences. Seeking to alleviate the pain and fear of childbirth, women demanded access to advances that

⁶ For a discussion of the emergence of the professional class and its impact on the welfare state, see Harold Perkin, *The Rise of the Professional Society: England since 1880*. New York: Routledge, 1989, 117-170.

modern science could offer, despite physician reluctance to provide anesthetized births.⁷ It just so happened that the medical profession's capacity to assuage some of the discomforts of childbirth developed in tandem with the ascension of hospitalized care. And it was in the *hospital* environment, more so than in the home birthing chambers, that women lost control of the birth experience. The dominance of science and its medical representatives in the experience of childbirth was in part a recognizable result of the growth of the stature and power of hospitals in health care delivery.

In 1872, the newly-founded provincial capital of Winnipeg established a Board of Health with the purpose of founding a civic hospital. While early in Winnipeg's development as a city, the arrival of a hospital in the Canadian city was at a time when their institutional status was gaining prominence in Britain and the United States.⁸ Despite an initial meeting of the board members in 1871, the Provincial letters of Incorporation were not taken out until December 13, 1872, when the provincial government was approached for assistance. Of note is the fact that only one physician sat on the Board upon the hospital's incorporation.⁹

⁷ Judith Walzer Leavitt, "Birthing and Anesthesia: The Debate over Twilight Sleep", *Signs*, 6:1, 1980, 147-165. Lawrence G. Miller, "Pain, Parturition, and the Profession: Twilight Sleep in America", in *Health Care in America: Essays in Social History*, Susan Rosner and David Reverby, eds. Philadelphia: Temple University Press, 1979, 19-43.

⁸ See Rosenberg, *The Care of Strangers*, 15-46.

⁹ Unknown, "Early Days of the Winnipeg General Hospital," *Manitoba Medical Bulletin*, 5-6 (July, 1926), 1. The members of the Board of Health upon the hospital's incorporation were: Messrs. Geo. Young, Gilbert McMicken, W. Kennedy, Joseph Royal, J.H. McTavish, W.G. Fonseca and Dr. J.H. O'Donnell.

A house at the corner of McDermot and Albert Streets in the central core of the city served as the initial site for the city's first medical institution. Site choice was based on a wish to place the institution at the most central location possible in order to allow for the city's future needs.¹⁰ By 1884, the hospital had acquired a permanent building, accommodating sixteen public ward patients and a small operating room.¹¹ Before arriving at its current situation on Bannatyne Avenue, the hospital was relocated five times, all within the boundaries of the city's center.

Historian Charles Rosenberg has identified a significant shift in the role of American hospitals towards the end of the nineteenth century, an era which he calls the "new healing order."¹² According to Rosenberg, the reputation of hospitals evolved from almshouse to modern, respectable institution in the latter half of the century, following the American Civil War. Canadian historian David Gagan has demonstrated how factors in the shift identified by Rosenberg also affected the evolution of Canadian medical institutions:

Antiseptic and aseptic procedures, the professionalization of nursing and, more importantly, of hospital administration wrought by Florence Nightingale and her disciples after 1870, the advent of new diagnostic technology (for example, the x-ray machine), improved surgical techniques and the clustering in one place of a steadily widening range of medical expertise all contributed to the growing perception among both

¹⁰ Unknown, "Early Days of the Winnipeg General Hospital", 1.

¹¹ Ross Mitchell, *Medicine in Manitoba: The Story of Its Beginnings*. Winnipeg: Stovel-Advocate Press, 1954, 77-78.

¹² Charles Rosenberg, *The Care of Strangers*, Part II.

physicians and their private patients that the hospital, not the home, was the preferred place for the treatment of acute sickness.¹³

The WGH came into its existence under this new scientific climate.¹⁴ Its introduction into turn of the century Winnipeg society paralleled that of scientific medicine into health care services.

As historian David Gagan argues, Canadian hospitals were predominantly perceived as charitable organizations for the ailing poor. As charitable institutions, they were imbued with the values of the members of wealthy benefactor classes who imposed their own moral authority. Gagan has described traditional hospitals as:

Custodial facilities maintained as secular charities by the wealthy patrons who in turn determined who should be admitted for care, hospitals were instruments of social control of the working and destitute urban poor, better equipped to promulgate Victorian social virtues than to treat sickness in the urban-industrial societies that gave birth to them.¹⁵

For their parts, doctors straddled the hinterland between a legitimate profession and a simple trade guild. Medicine had not yet garnered for its practitioners the respectability accorded to physicians of today. Conscious of the moral order as defined by hospital

¹³ David Gagan, "For 'Patients of Moderate Means': The Transformation of Ontario's Public General Hospital, 1880-1950", QSEP Research Report No. 239, November, 1988, 2. See also David Gagan, *'A Necessity Among Us'*, 28-29.

¹⁴ For an account of many of the scientific advances influencing physicians in this period, see Michael Bliss, *William Osler: A Life in Medicine*. Toronto: University of Toronto Press, 1999.

¹⁵ David Gagan, "For 'Patients of Moderate Means': The Transformation of Ontario's Public General Hospitals, 1880-1950", *Canadian Historical Review* LXX:2, 1989, 152.

financial supporters and in need of societal approval, physicians maintained the social mores of their institutional benefactors.¹⁶

Medicine itself could offer no clear legitimacy to the notion of benevolent buildings for the sick. Indeed, therapeutic resources offered by physicians could be provided outside the hospital just as well as they could be provided inside the hospital in the mid to late-nineteenth century. Consequently, the stature of hospitals did not change immediately and hospitals retained their status as charity refuges for the urban poor.¹⁷ The problem of hospital stature was further compounded by the taint of “hospitalism”, a justifiable fear of fever and infection contracted within hospitals and especially associated with lying-in wards.¹⁸

Through the 1880s, however, the perceptions of medicine, and consequently hospitals, began to change in North America. The science of bacteriology and the professionalization of physicians and nurses influenced the evolution of hospitals, which sought to associate with both in order to gain legitimacy. Advances in diagnostic and treatment techniques better suited to hospital conditions, also helped transform perceptions of hospitals in the eyes of both professionals and the public.¹⁹ Increasingly, hospitals were being frequently by middle-class patients able to pay the lower fees of

¹⁶ For a discussion of middle-class social mores and charitable institutions, see Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890 - 1935*. N.Y.: The Free Press, 1994, 55, 72.

¹⁷ Charles Rosenberg, *The Care of Strangers*, 115.

¹⁸ Charles Rosenberg, *The Care of Strangers*, 122.

¹⁹ Gagan, "For 'Patients of Moderate Means,'" 152.

semi-private wards. By the end of the First World War, hospitals were recognized as cornerstones of health care delivery and medical practice.²⁰ Nevertheless, for the most part, patients remained at the two socio-economic extremes of society: the very poor desperately seeking whatever medical attendance they could obtain in the public wards, and the very rich paying their personal physicians to attend them in the sanitized surroundings of the private wards.

Incorporated as a civic hospital in 1875, the WGH quickly embodied the characteristics of a modern hospital through its association with the Manitoba Medical College and the establishment in 1887 of a training school for nurses. Early in its existence (1890), the hospital adopted an elected board and a medical advisory committee, incorporating the expertise of local businessmen and social reformers, and acquiring legitimacy through association with scientific medical knowledge. The hospital demonstrated a commitment to the principles of public health through the maintenance of a district nursing programme (established in 1897), a permanent outdoor (or out-patient) department (established in 1905) and the first social service department in western Canada (established in 1909).²¹ These public programs attested to the 'charitable' legacy of hospitals, and continued services to the poor despite the presence of paying patients. The outdoor work was intended for "the relief of those who are too poor to pay medical

²⁰ See Starr, Paul, *The Social Transformation of American Medicine*. New York: Basic Books, Ch. 4.

²¹ From information included in WGH Annual Reports, 1884-1920. Available through Provincial Archives of Manitoba (hereinafter PAM), MG 10 B11, Box 1.

fees, and not sick enough to be admitted to a hospital";²² the social service department provided for "the appointment of some official connected with the hospital whose duty would be to visit the homes of the needy patients, visit discharged patients and see that they are put in a position to carry out the doctor's orders, to relieve the anxiety of patients in the public wards of the institution".²³

From the moment of its inception in 1872, the WGH struggled to accommodate demands upon its resources. As explained in the first chapter, the city of Winnipeg underwent a series of growth spurts from the 1880s to the 1920s. The increase in patient load at the hospital was partially a result of simple demographics. However, Chart I demonstrates that the patient numbers did not parallel the growth of the city. While the number of patients increased between 1891 and 1901, the proportion declined again in 1911. The proportion of Winnipeg residents in hospital vacillated between 4% and 7%. Nonetheless, it was clear that more people were making use of the hospital.

Characteristic of many health care institutions of the late nineteenth century, the WGH struggled to supply the needs of an increasing faith in hospitalization among medical professionals and lay public alike. By the First World War, the patient population had increased dramatically. Throughout the 1910s and 1920s, the hospital underwent successive renovations and constructions to keep pace with the increase in patient load.²⁴

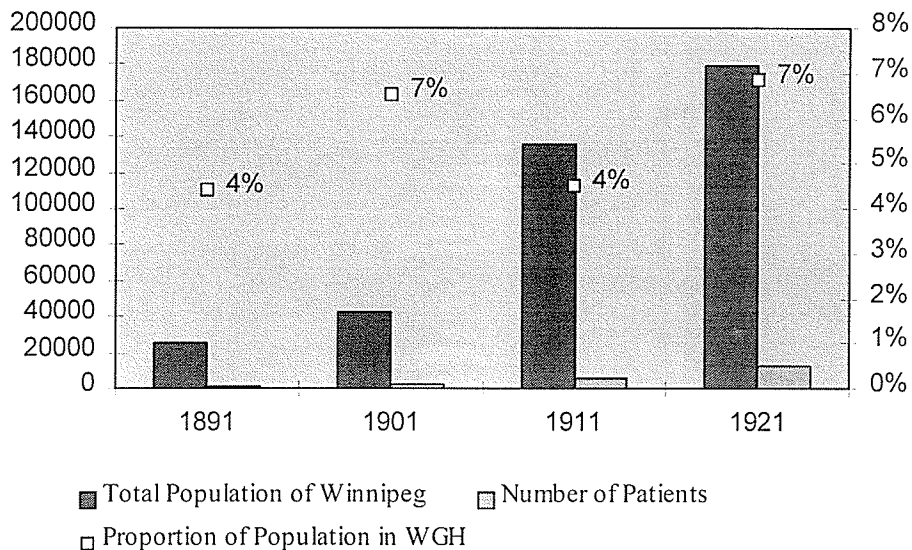
²² Annual Report, WGH, 1909, 11.

²³ Annual Report, WGH, 1910, 11.

²⁴ See Annual Reports, WGH, 1884-1920.

Chart 1

Proportion of Winnipeg Population Listed as Patients at the
Winnipeg General Hospital, 1891-1921



Source: Annual Reports, WGH. PAM, MG 10 B11, 1888-1925. See Chapter 3, Appendix I, Table II.

As noted, the steady increase in the number of patients was partially attributable to general population growth in the city; however, leveling in the city's population surge just prior to the First World War did not have much of an impact as numbers of patients continued to rise. It is likely that returning veterans contributed to the flood; nonetheless, escalating patient numbers demonstrated a growing trust in the hospital environment.

Ever-increasing demand produced a constant search for beds to oblige the patient population. Even after the hospital had moved to its permanent location in 1884, the medical superintendent lamented lack of space, especially in private and isolation

wards.²⁵ Insufficient private ward space became a recurring issue. Revenues generated from this source was undoubtedly a major reason. The charge for a room in the private wards was between \$2.00 and \$2.50 per day. For this sum, patients received “board, medicines, dressings and ordinary nursing attendance.”²⁶ To obtain a private room, patients had either to pay in advance or furnish adequate guarantee of payment. The main advantage of private accommodation was that patients were entitled to be attended by their personal physician rather than a staff doctor. With the opening of the hospital on Bannatyne Avenue, there were six private wards.

An increasing demand among the middle-class and wealthy for access to hospital treatment augmented the importance of private fees to the institution. Gagan has shown that hospitals in Ontario began to depend more and more on patient fees as an integral form of income.²⁷ The revenue shift resulted from “the rapid increase after 1900 of surgical and obstetric cases which became the hospital’s *raison d’être* by 1914; improvements in patient management which reduced the length of hospital stays by nearly 40 per cent between 1893 and 1908 and allowed the hospital to treat many more patients without increasing its actual capacity; and the developing perception on the part of the town’s physicians, that the Hospital was the preferred location for the treatment of

²⁵ Report of the Medical Superintendent, Annual Report, WGH, 1890, 15. PAM MG 10 B11, Box 1.

²⁶ By-Laws, WGH, October 1895, 13. PAM MG 10 B11, Box 10.

²⁷ David Gagan, "For 'Patients of Moderate Means'", 158. See also, Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality", in *A Not Unreasonable Claim: Women and Reform in Canada, 1880's-1920's*, Lynda Kealey, ed. Toronto: The Women's Press, 1979, 133.

their acutely ill private patients.”²⁸ By the First World War then, hospital clientele had already changed significantly. Instead of a mostly indigent patient base, like characteristic hospitals of the nineteenth century, early twentieth century hospitals operated more as businesses, depending on client fees for financial support.

The growing demand for private patient accommodation at the WGH became the subject of newspaper commentary. One story from an undated newspaper article stated:

The directors of the Winnipeg General Hospital have for some time past been urging the great necessity for a substantial addition to the accommodation of the institution. With the remarkable increase in the population of the city and the west during the past few years, the demands on the hospital have increased proportionately, but without provision made to meet them. Even the applicants for private rooms, who are willing to pay for their accommodation and attendance, are unable to secure rooms and yesterday there were no fewer than 13 applicants on hand which could not be met.²⁹

By the early 1900s, the Winnipeg General represented modern medical knowledge and expertise in the city. The hospital struggled to enlarge facilities and increase the availability of private rooms. Year after year, the medical superintendent’s report decried the lack of sufficient private accommodation to meet demand.³⁰ The addition of seven new private wards in 1894 alleviated the demand on the WGH temporarily. But rising admissions quickly swamped the hospital’s new capacity. In 1897, the WGH undertook

²⁸ David Gagan, "For 'Patients of Moderate Means'", 158-59.

²⁹ Quotation from scrapbook of loosely dated newspaper articles in the 'Winnipeg General Hospital Collection' of the Manitoba Provincial Archives. PAM MG 10 B11, Box 29.

³⁰ Report of Medical Superintendent, Annual Report, WGH, 1890, 1891, 1894, 1896. PAM MG 10 B11, Box 1.

construction of a brand new wing, the Victoria Jubilee Addition, hoping yet again to assuage the pressure.³¹ A *Winnipeg Free Press* article dated November 29, 1902, likened the abilities and strains of the WGH to those of well-known eastern Canadian institutions:

The citizens of Winnipeg have been accustomed to hear so much about the magnificent and richly endowed hospitals of large cities in the east, that they fail to realize the high relative position which their own general hospital takes, in regard to both the equipment and work. Comparing numbers of patients treated last year, the work of the Winnipeg General Hospital stands high in importance. The figures reported are as follows: Winnipeg General, 2,773; Montreal General, 2,823; Royal Victoria, 2,773; Lakeside Hospital, Cleveland, Ohio, 2,475; St Luke's, Chicago, 2,362.³²

The increasing demand for private accommodation points to a significant elevation in the reputations of hospitals. They were losing their gruesome shadow from the nineteenth century which cast them as institutions of desperation and death. Social change was enhancing their profiles and placing medical institutions in a much brighter, and more respectable, light.

Through admission procedures, by-laws, and the creation of an environment more palatable to the expectations of paying clients, the WGH also accommodated middle-class patients whose income was limited, but who could still afford to pay some of the expenses of their lodging and medical attendance. Most notably in 1899, the WGH introduced the concept of semi-private accommodation. Under this arrangement, patients could be attended by any provincially recognized physician provided they covered the professional fees. A fee of \$1.00 per day would be charged for "board, medicine,

³¹ Annual Report, WGH, 1897. PAM MG 10 B11, Box 1.

³² Scrapbook, 'Winnipeg General Hospital Collection', PAM MG 10 B11, Box 29.

dressings, and ordinary nursing attendance but any special wines and liquors that may be prescribed and any special attendance” was to be paid for by the patient.³³ The semi-private environment allowed for the inclusion of a new class of patient in the wards; one not part of the traditional classes found in medical institutions. The consumption of hospital services by this middle-class attests to the growing acceptance of hospital care within the scope of standard medical care. As with other medical institutions in the early twentieth century, the hospital’s reputation within the Winnipeg community was changing, and altering the character of health care delivery.

The most revealing indicator of increasing hospital utilization, however, was the fact that many more people were looking to medical institutions and hospitals for assistance with the most significant events in their lives - births and deaths. Susan L. Smith and Dawn D. Nickel have identified a historical parallel between births and deaths, arguing that the hospital replaced the home as the primary locus of both events in the twentieth century.³⁴ Chart 2 shows that the number of deaths occurring in hospital increased slowly, but steadily, between 1888 and 1925. Again, the increased use of hospital facilities was attributable in part to overall population growth. Further, the destitute continued to die in hospital as a vestige of the hospital’s nineteenth century character. Statistics do not provide a social class breakdown of those who died in

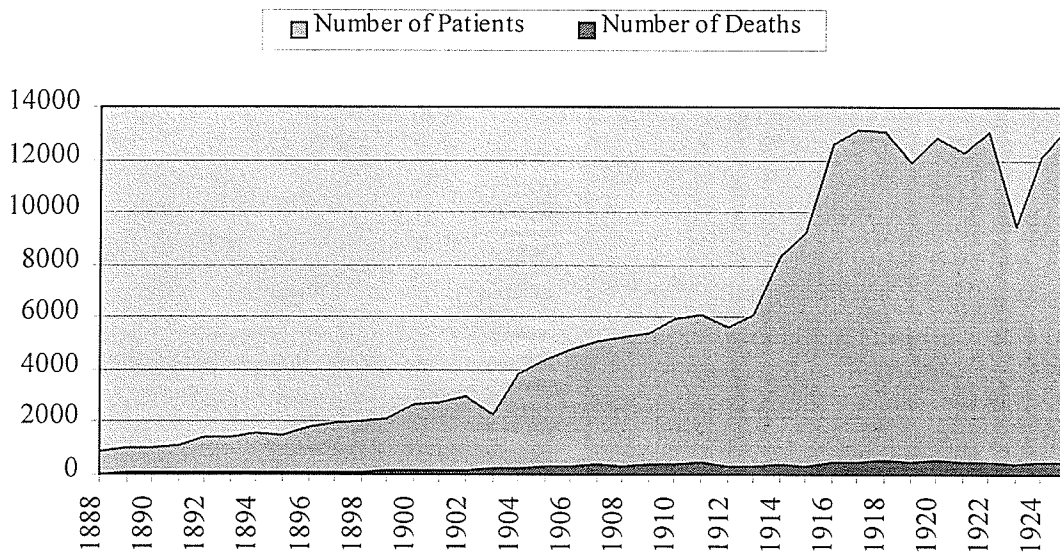
³³ Minutes, Board of Trustees Meeting, WGH, 30th September and 16th October, 1899. PAM MG 10 B11, Box 15.

³⁴ Susan L. Smith and Dawn D. Nickel, "From Home to Hospital: Parallels in Birthing and Dying in Twentieth-Century Canada," *Canadian Bulletin of Medical History*, 16 (1999), 49-64.

hospital care. However, given that the increased number of deaths did not directly mirror the increase in patient numbers, some of the rise in hospital deaths may be attributed to growing public and professional acceptance of hospitals as treatment facilities.

Chart 2

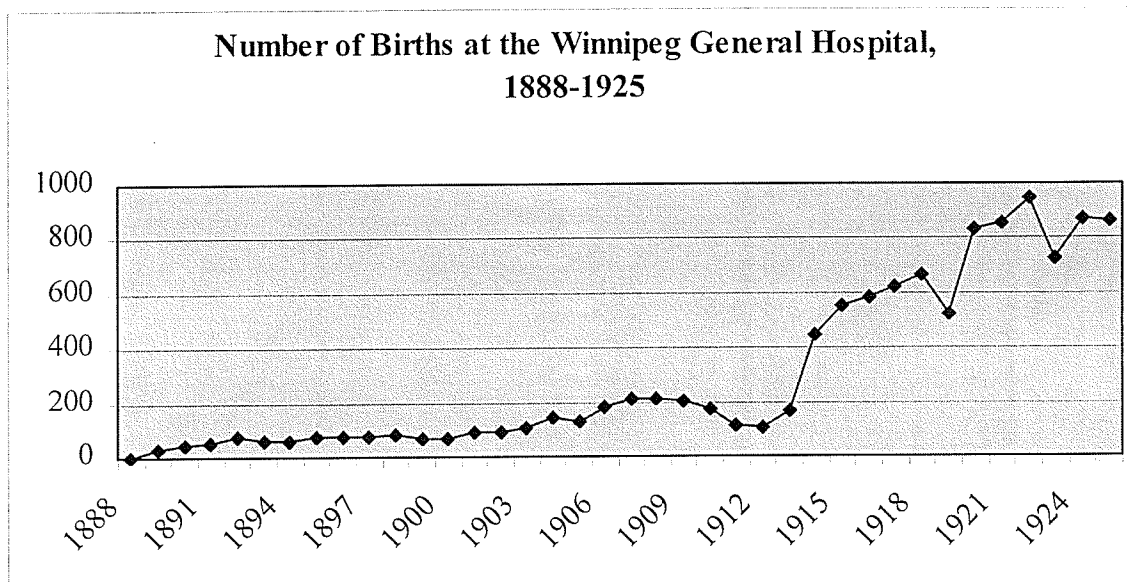
Number of Deaths at the Winnipeg General Hospital



Source: Annual Reports, WGH. PAM, MG 10 B11, 1888-1925. See Chapter 3, Appendix 1, Table II.

Increase in the annual number of hospital births also attests to the developing faith in medical institutions. Chart III shows that annual births attended at the WGH increased only marginally before 1903, slightly more between 1904 and 1914, and significantly starting in 1915 with some decline during the early years of the First World War.

Chart 3



Source: Annual Reports, WGH. PAM, MG 10 B11, 1888-1925. See Chapter 3, Appendix 1, Table II.

Again, multiple factors would have influenced the number of births in hospital - population growth, maternal choice, physician demand, a growing middle-class more able to pay for services. As Table 1 shows, while overall there was a rise in hospital use for births and deaths, it was not a steady increase. The totals as a proportion of the city's overall births and deaths was variable, rising and falling over the years.

Table 1

Year	Number of Births in Winnipeg	Number of Deaths in Winnipeg	Number of Births at the Winnipeg General Hospital	Number of Deaths at the Winnipeg General Hospital	Proportion of Births at the Winnipeg General Hospital	Proportion of Deaths at the Winnipeg General Hospital
1889	816	600	29	82	4%	14%
1890	842	458	46	82	5%	18%
1894	1051	571	63	99	6%	17%
1898	1313	547	85	111	6%	20%

Year	Number of Births in Winnipeg	Number of Deaths in Winnipeg	Number of Births at the Winnipeg General Hospital	Number of Deaths at the Winnipeg General Hospital	Proportion of Births at the Winnipeg General Hospital	Proportion of Deaths at the Winnipeg General Hospital
1899	1378	769	69	153	5%	20%
1901	1374	820	70	156	5%	19%
1902	1480	1094	93	177	6%	16%
1903	1811	1304	109	250	6%	19%
1904	1969	1449	141	271	7%	19%
1905	2062	1471	127	332	6%	23%
1906	2810	2093	181	317	6%	15%
1907	3521	1741	211	387	6%	22%
1908	3954	1500	211	327	5%	22%
1909	4100	1454	201	356	5%	24%
1910	3980	1803	178	405	4%	22%
1911	4674	2088	111	436	2%	21%
1912	5282	2407	108	283	2%	12%
1913	5577	2204	166	348	3%	16%
1914	5789	1955	446	384	8%	20%

Source: Manitoba Department of Agriculture and Immigration, *Report of the Department of Agriculture and Immigration, 1889, 1890, 1894, 1898, 1899, 1901-1904*; and Province of Manitoba, *Bureau of Statistics Births, Marriages, Deaths and Mortality Statistics for the Year Ending 1914*. Winnipeg, 1916, 14-17.

Nonetheless, physicians and the hospital were becoming increasingly present in people's lives during significant life events. Medicine was being perceived differently than it had been perceived hitherto; the role of doctors in society at large was being reshaped.

Hospitals retained ties to their former gloomy aspects through the public wards intended for poor patients. At the turn of the century, public wards served to legitimate government funding to a private institution. In return, the institution would provide medical attendance free of charge to those demonstrating need. The Board of Trustees of the WGH was sensitive to the hospital's dual status as a private institution and a public service organization. This sensitivity was manifest in the tight reigns maintained by the

Board over activities of staff physicians on hospital wards. Initially, when hospitals were primarily charitable institutions, administrators had forbidden physicians to accept fees even from private patients for services provided in hospital.³⁵ Later, as wealthier patients sought hospital care, both physicians and the institution recognized the value of private patients as potential income sources. Nonetheless, hospital administration remained protective of the hospital's role in providing for charitable cases.

In September of 1887, the WGH Board of Trustees expressed disapproval upon learning that some members of the Medical Board had been charging patients in the public wards.³⁶ Later the same month, faced with a request from physicians that they be allowed to charge public patients, the Board refused on the grounds that the hospital was a publicly funded institution. "The Hospital is supported by a grant under the charity act from the local Government of Manitoba, the grounds for such grant being that it is to meet the cost of affording gratuitous medical and maintenance to the sick and injured," remarked the Board Minutes of September 30th, 1887. The Board went on to declare that "to sanction therefore the charging of medical fees in the public wards would be destructive of the principles on which this like other secular hospitals, has been established, and maintained, and would eventually lead to the withdrawal of the financial support which it is now so generously receiving."³⁷

³⁵ Starr, *The Social Transformation of American Medicine*, 163.

³⁶ Minutes, Board of Trustees, WGH, 16 September, 1887. PAM MG 10 B11, Box 15.

³⁷ Minutes, Board of Trustees Meeting, WGH, 30 September, 1887. PAM MG 10 B11, Box 15.

The funds received through the public purse were significant enough to incur the protection of the hospital's administrators. Nonetheless, there was a patriarchal tone in the Board's decision and its attitude towards physicians indicating that medical practitioners were not the ultimate administrative decision-makers. In its denunciation of the request, the Board expressed concern over the maintenance of professional reputations, those of both the hospital and the physicians serving it. As the Board minutes stated, "to allow a rule which would enable them [physicians] to charge patients in the public wards, would be to place them in a position where they might be charged with filling the Hospital with their own patients where they would receive every comfort and the most careful trained nursing; and thus place all other medical practitioners at a disadvantage; and thus practically prevent the admission of many sufferers entitled to receive the advantages of public benevolence."³⁸ The Board's tone suggests that business considerations may have been a motivating factor for physicians seeking hospital affiliation, even at this early date.

The Board of Trustees maintained control over admissions to the hospital. This control was not unusual in the early days of modern hospitals. The practice survived from the hospital's derivation from charitable organizations. As the nineteenth century waned, admission decisions became increasingly medical ones in American and Canadian hospitals, but the vestige of lay administrative control remained.³⁹ At the WGH in the

³⁸ Minutes, Board of Trustees Meeting, WGH, 30 September, 1887. PAM MG 10 B11, Box 15.

³⁹ Rosenberg, *The Care of Strangers*, 274; Gagan, 'A Necessity Among Us', 49-50.

1890s, the medical superintendent was responsible for admitting patients, but the Board decided on the number of free patients to be admitted and the terms upon which paying patients received treatment.⁴⁰

Another remnant of the charitable organization days manifested itself in the concern for fraud. Hospital trustees felt that certain patients abused the system by claiming destitution and seeking admittance to the public wards, despite having sufficient funds to cover the cost of medical attendance either at home or on a private ward. The notion of the ‘deserving poor’ was of course a cornerstone of social and charitable endeavours in the nineteenth and twentieth centuries.⁴¹ This problem was perceived to be even greater in the “Outdoor Department”, where thousands of patients received clinical care every year, and an effective means test unavailable. As American historian Rosemary Stevens has shown, outpatient departments were a response to the progressive marginalization of indigent patients. With the middle and upper classes increasingly seeking hospital care, hospital boards sought to accommodate greater numbers of paying patients in the wards, and looked to outpatient services to free ward space. Consequently, ‘outpatient abuse’ was watched for vigilantly by both charity-givers and private practitioners, “lest it affirm free (or inexpensive) care as a right, and divert potential paying patients away from private practices”.⁴²

⁴⁰ By-Laws, WGH, October 1895, 3. PAM MG 10 B11, Box 10.

⁴¹ Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890-1935*. N.Y.: The Free Press, 1994, 1-3.

⁴² Rosemary Stevens, *In Sickness and In Wealth: American Hospitals in the Twentieth Century*. N.Y.: Basic Books, 1989, 49-50.

Eligibility in relation to public wards and services was on-going issue in WGH Annual Reports. The outpatient department was particularly scrutinized. Year after year, the Report stressed the need to curtail abuses of the system. “The care in the out-door department is supposed to be strictly confined to those patients who are unable to pay fees to regular practitioners,” claimed the 1903 Report, “and every care will be taken to see that this regulation is strictly adhered to.”⁴³ Even as the decade progressed and the hospital took on more private patients, the issue of ‘ability to pay’ remained a constant:

This [outdoor work], however, is a class of work that, while necessary, should be limited as much as possible. It is necessary for the relief of those who are too poor to pay medical fees, and not sick enough to be admitted to a hospital, but as those in good financial circumstances frequently attempt to take advantage of the free treatment given, the work should be done under proper supervision, and every questionable case investigated.⁴⁴

Thus, all who sought subsidized care were carefully and skeptically scrutinized. This scrutiny was not however, a feature of hospitals alone. Free care to indigent patients fell in line with the prevailing social welfare ideology of the late nineteenth century. A fundamental concept of welfare programs of the day was the “social minimum”, a limited provision that would ensure survival but discourage dependence.⁴⁵

Rules and regulations of the WGH over the first two decades of the twentieth century attest to the increased admission of wealthy private patients. Initially, hospital

⁴³ Annual Report, WGH, 1903, 11. PAM MG 10 B11, Box 1.

⁴⁴ Annual Report, WGH, 1909, 11. PAM MG 10 B11, Box 1.

⁴⁵ Term used by Denis Guest in *The Emergence of Social Security in Canada*. Vancouver: University of British Columbia Press, 1980, 3-4.

caregivers did not have to consider issues of social status; neither did they seem to concern themselves with the belongings or sensitivities of admitted patients. The regulations for 1912, for example, consisted simply of determining the appropriate ward for the patient, based on his ability to pay, and gathering medical information. All patients were admitted by the medical superintendent on an availability basis. Arrangements were made according to patient ability to pay.⁴⁶ Upon admission, the following pertinent information was gathered: name, age, religion, birthplace, residence and diagnosis. This information was inscribed in the patient's chart which hung at the foot of her or his bed.⁴⁷ By 1921, medical inquiry and economic determination remained, but other admission procedure changes required patients to turn over their clothing and valuables to the hospital.⁴⁸ A patient with valuables suggested to caregivers elevated socio-economic status. The regulations also stressed, adhering to middle-class modesties, that "patients not be exposed while being dressed or examined" and that "female patients must not be examined without a nurse in attendance."⁴⁹ Such by-law accommodations suggest a fundamental shift in the socio-economic character of the patient body.

Wendy Mitchinson has shown that in the late nineteenth century the overwhelming majority of patients in Canadian hospitals were men.⁵⁰ Other scholars'

⁴⁶ Rules and Regulations, WGH, 1912, 3-4. PAM MG 10 B11, Box 10.

⁴⁷ By-Laws, WGH, 1904, 10. PAM MG 10 B11, Box 10.

⁴⁸ Rules and Regulations, WGH, 1921, 12. PAM MG 10 B11, Box 10.

⁴⁹ Rules and Regulations, WGH, 1921, 7. MG 10 B11, Box 10.

⁵⁰ Wendy Mitchinson, *The Nature of their Bodies*, 55-56.

work has provided significant evidence that hospital patients during the nineteenth century were from poorer socio-economic strata.⁵¹ Hospital regulations reflected the middle class moral attitudes of physicians and administrators who outlined such rules. Middle class beliefs concerning the mores and values of the working class poor would not have suggested a need that early hospital regulations cover matters of respect for the modesties of patients. In fact, there is a conspicuous absence of provisions for decorum in the earlier regulations, as might be expected where patients were composed primarily of the desperate and non-paying poor. But as increasing numbers of middle and upper class women were admitted to hospital, respect for their ability to pay was matched by respect for decorum, and modesties became represented in hospital regulations.

The regulations of 1921 stressed the need for hospital staff to exhibit courtesy at all times since “of vital importance to the Institution [are] the attitudes of friends, relatives, and patients after the termination of their particular case.”⁵² Poor reputation can cause the ruin of any business; the hospital was no exception.⁵³ By the 1920s the hospital had begun to depend on revenues provided by private patients. It could not afford to lose status among the wealthy in the community who sought the best medical attendance that money could buy.

⁵¹ See Gagan, *A Necessity Among Us*, 13; and Agnew, *Canadian Hospitals*, 1.

⁵² Rules and Regulations, WGH, 1921, 6. PAM MG 10 B11, Box 10.

⁵³ This echoes the business practices of many modern proprietors. Consider the following capitalist aphorisms: ‘The customer is always right’; and, ‘If you have a complaint, tell me; if you have a compliment, tell others’.

The hospital protected its moral reputation fiercely. Consider a 1920 case in which a young physician, in badly diagnosing a patient, opened the hospital to the suspicion it was performing abortions. The physician, identified as Dr. Laidlaw, performed a curettage on a woman who was suffering from a continuous pain in her side. At a staff meeting following the procedure, Laidlaw was subjected to severe inquisition. He was ultimately dismissed from the hospital:

Dr. Laidlaw states that he was consulted about 2 weeks ago by the patient who gave a history of pain in the side for the past five or six years, during the last two weeks the pain was continuous. Dr. Laidlaw decided it was appendix. Patient gave a menstrual history of cramps and irregularity. Dr. Laidlaw said he would do something for that. She denied pregnancy. Dr. Laidlaw in the operating room of the WGH began by passing a sound and he found the uterus enlarged. Miss Patton said, "Is she pregnant". Dr. Laidlaw said he did not think so. He curetted and obtained a specimen, there seemed to be a mass in one corner of the uterus, there was no sign of a fetus. The canal was lightly contracted and needed dilatation before the curette could be passed.⁵⁴

It was apparent throughout the inquiry that the institution's primary concern lay, not with any danger posed to the patient by an invasive medical procedure or potential misdiagnosis, but with the impact of Laidlaw's actions on the hospital's reputation. Remarked Dr. Moody, one of the hospital's leading physicians: "This case leads to a suspicion of an abortion. Don't you think a doctor should protect the institution?"⁵⁵

But surely the more important and basic issue in this case was the potential misdiagnosis of a female health condition. Without the actual record of the case, there

⁵⁴ Staff and Executive Minutes, WGH, 17 January 1920. PAM MG 10 B11, Box 12.

⁵⁵ Staff and Executive Minutes, WGH, 17 January 1920. PAM MG 10 B11, Box 12.

exists no means to evaluate the thoroughness of Laidlaw's examination, the medical evidence upon which he acted, his clinical judgment, or what may have led him to discount pregnancy. However, the vagueness of the language and the noticeable absence of specific medical terminology suggests a lack of precise knowledge with respect to this patient's condition. Neither the board nor Laidlaw gave indication that they were comfortable in diagnosing a female condition. The workings of the female body seemed a bit of a mystery to them.

Regardless of their deficient understanding of the workings of the female body, however, physicians were becoming increasingly involved in parturient care. As shown throughout this work, the involvement of physicians in childbirth attendance represented a careful negotiation between women and doctors. Nowhere is this better illustrated than in the beginnings of maternity care in Winnipeg. These origins were a result of benevolent women's organizations providing homes for wayward girls. Historian Naomi Griffiths has shown how benevolent women's organizations at the turn of the century, operating in a world without a social welfare system, assumed responsibilities for the poor that were ultimately taken on by the state. Voluntary women's organizations organized and funded a myriad of social care institutions, including homes for the aged, for orphans, for refugees, and for 'friendless' women in lying-in hospitals.⁵⁶

Benevolent women's organizations of the early 1900's were fortified by the ideologies of social reform and maternal feminism. Maternal feminism argued that

⁵⁶ N.E.S. Griffiths, *The Splendid Vision: Centennial History of the National Council of Women of Canada, 1893-1998*. Ottawa: Carleton University Press, 1993, 5.

women had a particular place in the public sphere because of their roles as mothers and care-givers. On this basis, many prominent female voices emerged at the turn of the century advocating social change.⁵⁷ The National Council of Women of Canada (NCWC), formed in 1893, exemplified this approach. These reformist women maintained that the health and welfare of the nation would be secured through ensuring the health and welfare of the family:

We, Women of Canada, sincerely believing that the best good of our homes and nation will be advanced by our own greater unity of thought, sympathy, and purpose, and that an organized movement of women will best conserve the greatest good of the Family and State, do hereby band ourselves together to further the application of the Golden Rule to society, custom and law.⁵⁸

In the eyes of maternal feminists, a woman's place was in the homes of the nation.

Maternal feminists were not alone in their concern for the well-being of the Canadian family. This sentiment was shared by the broader social reform movement. At the turn of the century the social reform movement was targeting mothers in its bid to change the social fabric of the nation. Industrial society had interfered with the maternal function. Social reformers wanted to restore mothers to their more salutary traditional

⁵⁷ Wayne Roberts, "'Rocking the Cradle for the World': The New Woman and Maternal Feminism, Toronto, 1877-1914", in *A Not Unreasonable Claim: Women and Reform in Canada, 1880's-1920's*, Linda Kealey, ed. Toronto: The Women's Press, 15-45.

⁵⁸ From the constitution of the NCWC. Cited in Alison Prentice et al., *Canadian Women: A History*. Toronto: Harcourt Brace Jovanovich, 1988, 180. For an early discussion of the NCWC, see Veronica Strong-Boag, *The Parliament of Women: The National Council of Women of Canada, 1893-1929*. Ottawa: National Museums of Canada, 1976.

roles. As Peter Bryce, chief medical officer for the federal immigration department, noted in a speech to the Canadian Medical Association:

In the centuries preceding the last fifty years, war, famine and pestilence prevented in large measure the increase of population and were accepted as agents of evil permitted through the mysterious dispensations of providence; but today it is the man-made agencies . . . and the innumerable machines of industry which have transformed civilized communities into hives of industry, have brought women from the home and field into factories, limited their maternal powers and instincts and set their intellectual and emotional faculties to do duty, replacing largely animal functions at once simple and primitive.⁵⁹

Perceived to be both problem and solution to social ills, mothers were ideal targets for reformers concerned about the overall degeneration of society.⁶⁰ Comacchio has shown the existence of a close association between social reformers and physicians.⁶¹ Women's voluntary organizations advocating for social reform were concerned about mortality attributable to childbirth and childbirth generally. It is not surprising, therefore, that hospital administrators and physicians would turn their attentions to childbirth and childbirth facilities, issues of grave concern to Canadian women.

In its first year of operation on Bannatyne Avenue, the WGH diagnosed only one pregnancy.⁶² Confinement was still largely a home care event or left to a smattering of maternity homes. The Ladies Maternity Hospital, under the direction of the Christian

⁵⁹ Cited in Cynthia R. Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*. Montreal: McGill-Queen's University Press, 1993, 18.

⁶⁰ Comacchio, *Nations are Built of Babies*, 11.

⁶¹ Comacchio, *Nations are Built of Babies*, 16-17.

⁶² Annual Report, WGH, 1884. PAM MG 10 B11, Box 1.

Women's Union (hereinafter CWU), was one of the most prominent maternity homes in the city. The CWU was organized in 1883 by three high-status women, Mrs. W.R. Mulock, Mrs. J.A. Aikins and Mrs. George Bryce. Its initial objective was to operate a hostel for "young women earning their living in the city but away from their homes."⁶³ However, when the hostel failed to attract this desired class of occupants, its nature and qualifications for admission were changed. It was now to be a maternity hospital for "unfortunate girls, poor married women and rural patients who might come to the city to secure good medical attention".⁶⁴ After two relocations, it served as the only medically recognized maternity care center in the city in 1887, when it was forced to close its doors following a second outbreak of scarlet fever.

Facing closure, the CWU Board of Directors approached the WGH "in regards to [the] Hospital taking charge of the maternity cases in future."⁶⁵ For the year 1887, only three accouchements had taken place in the WGH. The WGH did have an interest in acquiring a maternity ward, but it was not willing to accept the CWU's proposal immediately. The hospital's Annual Report for 1887 remarked on the possibility:

At present, there is no room for such work, and it can only be cared for in a separate and isolated building. No result has yet been arrived at, but the Board are quite prepared to render every assistance in their power to provide, as part of the general work of the Hospital, a ward for maternity cases. This would add a great deal to the usefulness of the School of

⁶³ Ross Mitchell, "Maternity Hospitals of Greater Winnipeg", in *Safeguarding Motherhood*, Winnipeg General Hospital, 1951, 23. PAM MG 10 B11, Box 10.

⁶⁴ Ross Mitchell, "Maternity Hospitals of Greater Winnipeg", 23.

⁶⁵ Annual Report, WGH, 1887. PAM MG 10 B11, Box 1.

Nurses and enable the Hospital to supply trained and skilled nurses for cases of maternity and accidents.⁶⁶

The Report remained silent on the usefulness of a maternity ward for the training of doctors, but the Board of Trustees noted that “both the Medical College and the Training School for Nurses would be very greatly benefitted by the existence of wards for maternity cases under the charge of the General Hospital.”⁶⁷ Evidently, childbirth was viewed as a component of the hospital training and education environment.

In February of 1888, the Board resolved to “erect a proper building for the treatment of maternity cases, to be carried on as part of the Hospital.”⁶⁸ For the first time, maternity services were to be included as a component part of a general hospital in Manitoba. By 1889, the maternity department had been established within the hospital with Drs. Chown and Gray appointed as chief maternity physicians. During its first full year of operation, a total of twenty-nine births occurred in hospital under maternity department auspices.

Initial negotiations between the hospital’s Board and the Directors of the CWU were clouded by misunderstanding. The hospital expected the CWU to continue in a funding role; however, the CWU, in fact, had relinquished all interest in maternity care. The exchange between the two boards was as carefully crafted as any social interchange

⁶⁶ Annual Report, WGH, 1887. PAM MG 10 B11, Box 1.

⁶⁷ Minutes, WGH Board of Trustees 30 April, 1888. PAM MG 10 B11, Box 15.

⁶⁸ Minutes, WGH Board of Trustees, 24 February 1888. PAM MG 10 B11, Box 15.

between a lady and gentleman of the period. In a letter requesting financial support from the WCU, the WGH Board noted:

that in November the Committee of the Ladies sought an interview with this Board, and asked them to take over the Hospital, which they were unable any longer to carry on, and at that interview the Directors stated that it would involve a very considerable expense for the necessary building, and that they expect to receive towards that outlay, the funds which were on hand for maternity purposes; and also that the Ladies would endeavour to further collections for the same object.⁶⁹

The response was unexpected. The CWU had only raised \$202.50 for the purposes of constructing a maternity hospital, and were quite adamant about retaining their Dominion funding for the purposes of launching a refugee service for immigrant women. In the outcome, the hospital received the small sum and the CWU withdrew completely from involvement in maternity care.⁷⁰

Despite CWU withdrawal, the Board proceeded with the maternity building construction. Accordingly, we can infer that the CWU request was not the Board's sole motivator. In fact, from the beginning the hospital's interest in the project seemed independent of the CWU. When initially approached, the Board agreed to consider any proposal submitted by the CWU. When the Board resolved to go ahead with its building plans in February of 1888, the CWU had submitted no proposal. On April 9, 1888, the Manitoba Medical College wrote the Board to press the urgent need to establish "suitable accommodations for the care of maternity patients."⁷¹ Thus, the motivation of hospital

⁶⁹ Minutes, WGH Board of Trustees, 29 March 1888. PAM MG 10, B11, Box 15.

⁷⁰ Minutes, WGH Board of Trustees, 30 April 1888. PAM MG 10 B11, Box 15.

⁷¹ Minutes, WGH Board of Trustees, 9 April 1888. PAM MG 10 B11, Box 15.

administrators to create an in-house maternity facility was quite separate from the stimulus provided by the CWU, and obviously shared by professionals at the Medical College. When the Board encountered opposition from city physicians who objected to the maternity facility's location, it passed a motion defending its decision:

[T]he Directors of the Winnipeg General Hospital have been induced to undertake the establishment of a Maternity Hospital, and have in a short space of time, made the necessary financial arrangements, and actually commenced the building, and whereas in the opinion of this meeting such a hospital is urgently required in this City, under a management which had at once the complete confidence of the public, and is able to carry out with thoroughness the requirements of such institutions.⁷²

The resolution demonstrated that the Board considered maternity care to be an important component of general hospital services. While there is no direct evidence in the Annual Reports or the Board Minutes, it can be deduced that the broader educational and economic benefits would not have been far from the minds of administrators and physicians.

By June of 1888, the WGH had accepted tenders for maternity ward construction. Building space had been allotted on the southwest corner of the hospital grounds. Though the medical community was generally supportive of these manoeuvres, it was not entirely in unison concerning the efficacy of a maternity ward connected to a general hospital. On June 4th the Board met to discuss a petition before City Council seeking to block construction by halting civic funding. A handful of city physicians argued that the proximity of parturient women to general hospital staff and accommodations would expose patients to numerous septic diseases. They also argued that provision of services

⁷² Minutes, WGH Board of Trustees, 4 June 1888. PAM MG 10 B11, Box 15.

to the poor would be hampered by the hospital's distance from the city center. As explained earlier, many of the city's immigrants and poor people indeed resided just north of the city center. The petitioners maintained that:

the Maternity hospital so much needed should be not only a refuge, but an institution in which immigrants of whatever class, high or low, can with safety place themselves if necessity arise, and also one to which settlers in our country, resident where it is impossible to get medical advice and skillful nursing, may confidently resort and obtain what medical skill they may desire to select.

The distance from the centre of the City without any street car connections exposes those seeking the shelter of the Maternity hospital to unnecessary danger and expenses, as well as being inconvenient to the general body of medical men whose services may at any time by day or night be required.⁷³

Not one of the petition's signatories was a member of the WGH medical staff. Indeed, business considerations may have motivated the petitioners. Confinement services could provide considerable financial rewards for physicians, especially where upper and middle class mothers were involved. Not only were there immediate service fees to consider, but also the long-term economic gain from becoming identified by the family as its ongoing trusted physician. A mother pleased with care received during confinement would be influenced to call the same provider when another family member required treatment. As Charles Rosenberg has observed,

[t]he hospital was a necessary stage for acting out the ambitions of those who would play an elite role in an increasingly competitive medical world - competitive in intellectual as well as economic terms. A hospital position would provide [the physician] not only with immediate professional recognition and an opportunity to hone his skills and make

⁷³ Minutes, WGH Board of Trustees, 4 June 1888. PAM MG 10, B11, Box 15.

professional contacts, but access to the pool of charity patients that provided indispensable raw material for scholarly work and publication.⁷⁴

Ultimately, the obstetrical department of the WGH was awarded civic funding. Despite protests from local, non-affiliated, practitioners, the province's largest hospital launched its obstetrical career in December of 1888. The new obstetrical unit was housed in a newly constructed two story brick building on grants from the City of Winnipeg (\$1500) and the Province of Manitoba (\$500). The facility boasted hot water and accommodation for fifteen public patients. There were four private wards.⁷⁵ In deference to concerns that its proximity to the general hospital would encourage the spread of infectious disease amongst parturient patients, the maternity hospital was erected 200 feet away from the main building. H. H. Chown and J. S. Gray were appointed as the first obstetrical medical staff. Obstetrical appointments, however, did not carry the same prestige as appointments to the hospital's regular medical staff claimed Ross Mitchell:

In those early years every doctor on the honorary attending staff was a general practitioner who was expected to turn his hand to every branch of medicine. Later a distinction was made in the staff between medicine and surgery, but for many years the newly-appointed doctor would serve a term in the out-patient department, then a term on obstetrics or infectious diseases before reaching the coveted goal of physician or surgeon.⁷⁶

⁷⁴ Rosenberg, *The Care of Strangers*, 168.

⁷⁵ Mitchell, "Maternity Hospitals of Greater Winnipeg", 25. The total cost of construction was \$7,349.40.

⁷⁶ Mitchell, "Maternity Hospitals of Greater Winnipeg", 26.

Thus, any newly appointed WGH physician paid his dues firstly in the maternity ward before acquiring a more prestigious appointment. The hierarchical structure of the medical staff identified obstetrics as a junior specialty within the profession.

Obstetrics as a profession struggled to establish itself. Since most births occurred in the home, patients admitted to the maternity hospital were mostly comprised of unfortunate girls, destitute women, rural patients without friends or family in the city, or difficult medical cases.⁷⁷ Undoubtedly, attendance on this class of patient could have negative repercussions on a physician's career. However, hospital maternity cases provided a young physician with clinical experience and expertise which could be parlayed into more lucrative and prestigious dealings with private patients. In his study of the emergence of hospitals in the United States, Paul Starr argued that a schism developed between physician recipients of hospital appointments, with their attendant professional benefits, and those excluded from such honours and rewards. Quoting from a 1907 volume of the *National Hospital Record*, Starr illustrated the dichotomy:

On the one hand we have a public educated to avail itself of the facilities of a hospital in severe illness, and on the other hand a cast-iron regulation which closes the doors of the hospital to the majority of practitioners. This 'system' has made such striking inroads on the earning capacity of physicians in cities where it flourishes as to entail enormous pecuniary losses."⁷⁸

⁷⁷ Mitchell, "Maternity Hospitals of Greater Winnipeg", 26.

⁷⁸ Cited in Paul Starr, *The Social Transformation of American Medicine*, 162-63.

Institutionally affiliated physicians were becoming identified with the positive reputations of science, technology and modernity. Accordingly, an attending position at a large teaching hospital such as the WGH offered the practitioner a valuable credential.

Even though admissions of maternity patients continued to rise, controversy also continued over the desirability of placing obstetrical facilities within a general hospital setting. In 1911, the maternity building was torn down to make room for an extension to the Nurses' Home. The WGH Board of Trustees assumed that other medical facilities would absorb the obstetrical patient load.⁷⁹ The medical staff swiftly appealed this decision. In the outcome, the Annex Nurses' Home was converted into a temporary maternity ward accommodating a total of thirteen patients.⁸⁰ It is worth noting that the proportion of parturient related cases in the hospital hovered at roughly 4% between 1889 and the closure in 1911.⁸¹ While not representing a significant amount of business for the WGH, physicians were keen to maintain maternity services. Their appeal indicates that medical professionals had an interest in confinement care which was not shared by the hospitals' administrators.

⁷⁹ Annual Report, WGH, 1911, 12. PAM MG 10 B11, Box 1. In 1898, the Misericordia Hospital opened as a maternity hospital only. In 1916, it became a general hospital. Also, in 1904, the Salvation Army opened the Grace Hospital to care for unfortunate girls and maternity patients.

⁸⁰ Annual Report, WGH, 1911, 12. PAM MG 10 B11, Box 1.

⁸¹ See Chapter 3, Appendix 1, Table II for data. Rough percentage obtained by dividing the number of births by the number of patients. Between 1889 and 1911, the percentages moved between 3% and 5%.

Since obstetrical attendance was considered a low rung on the ladder of medical treatment hierarchy, it is interesting that the medical staff petitioned for the continuation of maternity services. This suggests that maternity care, though not on the same level of prestige as other medical specialties, was coming to be considered by many as an important part of general medical practice and a legitimate branch of institutional medicine. This perception may have been reinforced by the publication in 1910 of the Flexner Report which examined the state of medical education in the United States. The Flexner Report was commissioned by the Carnegie Foundation and can be seen as a turning point in medical education.⁸² Undoubtedly, it influenced teaching hospitals and training programs in Canada. The report openly criticized the lack of clinical experience in obstetrical training, and denounced the failure of medical schools to make appropriate arrangements for students to acquire hands-on obstetrical practice.⁸³

From its inception, the WGH maternity units drew a distinct line between public and private confinement patients. Public ward patients endured restricted movement and dress. They were allowed to wear only clothing provided by the institution. The amount of care they could receive was limited. They were to be admitted no more than two weeks prior to their anticipated dates of delivery. Public ward patients were to “rise at 6:30 A.M. in summer and 7 A.M. in winter”. They were “expected to make their own beds,

⁸² Rosenberg, *The Care of Strangers*, 209-211; Starr, *The Social Transformation of American Medicine*, 120-21.

⁸³ Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge, Mass.: Harvard University Press, 1995, 104.

and assist in keeping the wards in order under the supervision of the nurse in charge.”⁸⁴

By contrast, private patients were unrestricted. Their only requirement was to demonstrate that they possessed the means to pay the daily \$2.00 fee.⁸⁵

The distinction between paying and non-paying patients helps to explain the ambivalent regard of medical men towards maternity care. Public ward patients were there through the hospital or community social services, and would not have represented an opportunity to access further business. They generated little revenue for physicians and offered little opportunity for professional advancement, other than the clinical experience they could provide. They were attended by staff physicians, who at least received the benefits of admitting privileges and an association with science, an important matter for a physician in private practice. In the case of teaching hospitals, such as the Winnipeg General, they could possibly be in the care of students or young physicians seeking clinical experience. Ironically, in this capacity, they would have offered to such physicians an invaluable learning experience, and represented an important link between childbirth and medicine.

Wealthy women had greater expectations of medical men; they expected relief from pain, a safer birth, and the expertise of science.⁸⁶ However, as we have seen in Chapter Two, doctors were still learning some of the basic mysteries of birth and often

⁸⁴ Minutes, WGH Board of Trustees, 8 October 1888. PAM MG 10. B11, Box 15.

⁸⁵ Minutes, WGH Board of Trustees, 8 October 1888. PAM MG 10. B11, Box 15.

⁸⁶ See Judith Walzer Leavitt, "Birthing and Anaesthesia: The Debate over Twilight Sleep", *Signs*, 6, 1980-81, 147-164.

had little to offer of a concrete nature during attendance in the home. The hospital environment was a different story. It at least gave the impression of science and expertise, sought after by both mother and doctor.

Once the maternity ward was in full operation, students from the Manitoba Medical College sought access to confinement cases. For a fee of \$5.00 a session, students were entitled to attend six cases.⁸⁷ This arrangement exposed the maternity ward to septic infection. The hospital sought to minimize exposure by imposing a strict regimen on medical students passing from the general hospital to the maternity wards. It compelled students to sign a declaration promising not to “visit or be present at cases of confinement in the Maternity Hospital when engaged in pathological operations, when recently engaged in dissecting, or when dressing putrid sores, under penalty of expulsion.”⁸⁸

A comparison of WGH patients at various stages of the hospital’s evolution provides some interesting snapshots of the hospital childbirth experience. As Paul Starr noted:

In a matter of decades, roughly between 1870 and 1910, hospitals moved from the periphery to the center of medical education and medical practice. From refuges mainly for the homeless poor and insane, they evolved into doctors’ workshops for all types and classes of patients. From charities, dependent on voluntary gifts, they developed into market institutions, financed increasingly out of payments from patients.⁸⁹

⁸⁷Annual Announcement of the Second Year Session, Manitoba Medical College, 1884-85.

⁸⁸ Minutes, WGH Board of Trustees, 8 October 1888. PAM MG 10. B11, Box 15.

⁸⁹ Starr, *The Social Transformation of American Medicine*, 146.

The WGH illustrated this shift in hospital function. On launching its maternity facilities in 1889, the culture of the WGH was still very much tied to its charitable past. As charitable cases, it was expected that public ward patients would contribute to the operation of the hospital through house-keeping and various daily duties. But by 1914 the hospital was developing into a modern, scientific institution. Patients were in hospital for a shorter period, and there were generally greater expectations - especially among private patients - about the care and catering.

Through an examination of patient socio-economic comparisons at these two points in the hospital's history, a picture emerges of the women who sought hospital births, and the impact on the community of medicine's broader social evolution.⁹⁰ The WGH Admitting Register for 1889, the maternity ward's first full year of operation, records twenty-nine confinement cases.⁹¹ None of the women listed as maternity cases were considered to be paying patients.⁹² A majority of these patients, seventeen in total, were British-born. Six others had been born in Canada. Of the remaining six, three were native Icelander, one was German, one was Danish-born and the last was American-born.

⁹⁰ For the purposes of this study, "snapshots" will be provided for 1889, 1899 and 1914. The choice of years has been determined, to some extent, by the available documents. Records retrieved from Winnipeg's Health Sciences Centre are only partially complete. Some years are altogether absent. 1909 is one of these. This explains why I was unable to provide statistics for 1909.

⁹¹ Admitting Register, WGH, 1 September 1882 to 31 December 1890. Provided by Health Records Department, Health Sciences Centre, Winnipeg.

⁹² Absence of private patient maternity records does not mean that private patients were not confined in hospital. It is likely that records of private patients were kept by the patient's private physician and not included with the hospital's general records.

The overwhelming majority (25 of the 29) were Protestant. The remaining four were Roman Catholic.⁹³ Most resided in Winnipeg (18) or Manitoba (8). Only two residents were from other parts of Canada.⁹⁴ Ages ranged from 15 to 33 with an average age of 24.⁹⁵ According to the register, non-paying maternity patients remained in hospital for approximately a month. However, the length of stay for each patient varied widely.⁹⁶ As a result, it is difficult to discern a specific pattern. Many patients, however, were admitted to hospital well before their confinement date, and remained up to several weeks after. Without specific patient records, it is impossible to know the circumstances surrounding hospital stays. Nonetheless, it can be concluded that a woman admitted for confinement would likely spend several weeks in hospital. Accordingly, a typical maternity patient at the WGH was in her mid-twenties and from a British-Protestant family. Records offer little information with respect to the health of the patient, the treatment delivered, or the actual birth. A typical birth involved hospitalization for approximately a month. If she was a public ward patient, as has been shown earlier, the

⁹³ Listed as Protestant: 3 Presbyterians, 13 Anglicans, 4 Lutherans, 5 Methodists.

⁹⁴ 18 listed Winnipeg, 8 listed places in Manitoba, 2 listed other Canadian sites, 1 was unknown.

⁹⁵ Both mean average and median average is 24 years.

⁹⁶ The Register provides the date of admission, the date of confinement and the date of release.

mother would likely have contributed to general cleaning and light maintenance of the ward.⁹⁷

The WGH maternity ward was even busier during 1899 with a total of 77 pregnancies listed and 67 births recorded in the Annual Report for that year.⁹⁸ The hospital's maternity registry, however, only listed 71 cases related to pregnancy, including 3 miscarriages and 2 deaths.⁹⁹ By 1899, the demographics of the maternity population at the WGH reflected the broader 'Canadianization' of the city. Of the 71 patients listed, 45% (32) gave Canada as their place of birth, 31% (22) reported Britain, while 20% (14) declared themselves to be of other heritage.¹⁰⁰ The religious affiliation of maternity patients remained overwhelmingly Protestant; 84% (60) affirmed a Protestant religious affiliation. Only 15% (11) declared an 'other' denomination.¹⁰¹ Only 13 patients resided outside of Winnipeg. Of these, most were from rural Manitoba. Mean age was 24.9 years

⁹⁷ As outlined in Minutes, WGH Board of Trustees, 8 October 1888. PAM MG 10. B11, Box 15.

⁹⁸ Annual Report, WGH, 1899. PAM MG 10 B11, Box 1. Totals included: "1 Abortion, 67 Births (2 death), 5 miscarriage, 7 threatened miscarriage, 1 miscarriage with sapraemia, 77 pregnancies, 2 pregnancies w sapraemia (2 deaths), 1 pregnancy w post partum haemorrhage, 1 pregnancy w chorea."

⁹⁹ General Registry - Maternity Cases, WGH, 1 January 1899 to 30 December 1899. Provided by Health Records Department, Health Sciences Center, Winnipeg. The Annual Report for 1899 lists 5 miscarriages; the registry lists only 3.

¹⁰⁰ General Registry - Maternity Cases, WGH, 1 January 1899 to 30 December 1899. Other heritage included: 11 other European and 3 U.S. Three were listed as unknown.

¹⁰¹ Protestant included: Church of England (22), Lutheran (6), Methodist (13), Presbyterian (15) and Baptist (4). 'Other' included Roman Catholic (5), Jewish (2), Congregationalist (2), Doukhobor (1) and Winnipeg Brethren (1).

old. Median age was 23 years. The oldest was 38; the youngest, 14.¹⁰² Each patient averaged approximately 20 days in hospital, representing a noticeable reduction from 1889. In summary, the average WGH maternity patient at the turn of the twentieth century was in her mid-twenties, white, Protestant, and had most likely been born in Canada. She might have expected to spend fewer days in hospital than she would have in the previous decade. It was also likely that she was poor and in the public ward. There were indications in the 1899 Registry that paying patients were being added to the hospital's registration system. A total of 6 patients were listed as having paid fees ranging from \$6 to \$134. If a public ward patient, it is likely she would still be expected to perform chores as part of her daily routine.

Though the 1914 Annual Report lists a total of 446 hospital births, only 22 patient files are available.¹⁰³ The information they record does not correspond to that provided through patient registries of previous years. Neither nationality nor religion was regularly recorded. In some ways, file information was more detailed. They included precise patient addresses within the city. And some files provide detailed treatment descriptions, including accounts of septic infections, their courses, and the methods used to combat their spread.

¹⁰² The mean age for childbirth in Canada in 1921 was 25.8 years. See Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939*. Toronto: Penguin Books, 1988, 147. See also Ellen Gee, "Fertility and Marriage Patterns in Canada, 1851-1971. Ph.D. Dissertation, University of British Columbia, 1978.

¹⁰³ *Affections Connected with Pregnancy and Consequences Thereon*, WGH. Health Records Department, Health Sciences Center, Winnipeg. For the purposes of this study, I have omitted the 4 patient files which deal with abortions.

While their paucity precludes full statistical evaluation, the records still offer insight into standard procedures surrounding confinement cases. The 22 medical history sheets available reveal an average maternity patient age of 26. The youngest patient was 16 and the oldest was 36.¹⁰⁴ Length of hospital stay, at approximately 10 days, had decreased to half that of the previous decade.¹⁰⁵ Only two patients listed residences outside Winnipeg; while two were residents of the Home of the Friendless, a local organization for pregnant unmarried women. Of the remaining 18 patients, 15 listed addresses in the north-west corner of the city, 1 in Transcona, and 1 in the north-east. The last file did not provide a street name. Four patients were recorded as unmarried, including one woman identified as being "in service".¹⁰⁶

While all cases were related in some way to pregnancy, only 12 were identified as childbirth attendances. Most represented uncomplicated births - left occipitoanterior (L.O.A) positions with vertex presentations - permitting reliance on conventional procedures.¹⁰⁷ Except for one patient, all were admitted while in labour and assigned to

¹⁰⁴ The mean and median ages were both 26.

¹⁰⁵ The median number of days in hospital was 9.5.

¹⁰⁶ Register Number 2526, *Affections Connected with Pregnancy and Consequences Thereon*, Winnipeg General Hospital. Health Sciences Center, Health Records Department, Winnipeg.

¹⁰⁷ L.O.A. connotes left occipitoanterior. This occurs during delivery when the back of the fetus' head is turned toward the mother's left acetabulum (the acetabulum is a cup-shaped depression on the external surface of the innominate bone, into which the head of the femur fits). L.O.A. births are usually uneventful and represent the great majority of birth presentations. "Vertex" presentation means simply that the top of the fetal head is first to enter the birth canal. Again, this represents the standard birth process. Things become very complicated with non-vertex presentations; e.g., breech

the on-duty physician, indicating that few were receiving regular and ongoing prenatal care. Five patients suffered lacerations during delivery, though only three files indicate the use of forceps. One case reveals severe postpartum hemorrhage that was treated with ergot.¹⁰⁸

The most detailed patient record belongs to a 16 year old girl from Bird's Hill, admitted in labour on December 26, 1914 and delivered by John McCalman. Her labour had begun on December 21. She had been treated at home with two doses of pituitary extract. Neither had had any effect.¹⁰⁹ The patient was brought to hospital after contractions ceased entirely. The delivery was extremely difficult. It required the use of high forceps. There was extreme moulding of the baby's head.¹¹⁰ After delivery of the placenta, there appeared some further loose tissue which the doctor sutured. The patient's

birth or shoulder presentation. See *Stedman's Medical Dictionary*, 21st edition. Baltimore: The Williams and Wilkins Co., 1966.

¹⁰⁸ Register Number 4685, *Affections Connected with Pregnancy and Consequences Thereon*, Winnipeg General Hospital. Health Sciences Center, Health Records Department, Winnipeg. Ergot is a disease of rye and other cereals in which the grains are replaced by a blackish purple mass of peculiar disagreeable odor. A medicine made from these growths causes contraction of the muscular coat of the arteries, raising blood pressure, and contraction of the uterine muscles.

¹⁰⁹ Pituitary extract is as a yellowish or grayish powder derived from the cleaned, dried and powdered posterior pituitary lobe of domestic animals used for food by man. It acts as an oxytocin, vasoconstrictor, antidiuretic, and a stimulant of intestinal motility.

¹¹⁰ The use of 'high forceps' is very dangerous to both mother and baby. It is rarely used in today's obstetrics, with caesarian section being preferred. Extreme moulding of the infant's head indicates that the infant's head has been subjected to intense pressures during its descent down the birth canal. Such elevated cranial pressures can produce subdural haematomas, and brain hypoxia, with both immediate and long-term clinical effects for the infant.

immediate condition was classified as 'fair'. She was given strychnine, whiskey, coffee and saline, all treatments of limited therapeutic value.¹¹¹ The patient had sustained extensive lacerations of the cervix, probably as a result of the high forceps use. She developed a high fever and was treated with ergot and restricted diet. By December 24, her pulse was weakening, and she was unable to sleep. The patient died on December 31, probably in septic shock.¹¹²

This story illustrates a bad outcome in a typical case of childbed fever. Such outcomes were not uncommon. They often included circumstances of difficult delivery and prolonged confinement. Without the availability of antibiotics, physicians were impotent to deal with the source of the escalating fever. McCalman's treatment was little different from that accorded any confinement patient facing post-partum complications - bed rest and relatively ineffective symptomatic medications to alleviate some of the patient's suffering. Attacking the etiological source of the illness was beyond the physician's power, either within hospital or in the home. It was not until the 1940's, with the widespread availability of antibiotics, that physicians could offer a specific effective treatment to combat post-partum infection.¹¹³

¹¹¹ Strychnine is a crystalline powder, odorless, but of intensely bitter taste nearly insoluble in water. It stimulates all parts of the nervous system and is used as a stomachic (appetite stimulant), as an antidote of depressant poisons and in the treatment of myocarditis.

¹¹² Register Number 7975, *Affections Connected with Pregnancy and Consequences Thereon*, Winnipeg General Hospital. Health Records Department, Health Sciences Centre, Winnipeg.

¹¹³ Leavitt, *Brought to Bed: Child-Bearing in America*, 194.

In 1914, charting for less complicated births was categorized similarly, sometimes with similar levels of descriptive detail. The charts were pre-formatted and appear standardized for every patient admitted. The depth of material recorded, however, varied extensively from chart to chart. Some notes are brief, providing a quick outline of the birth; others offer finer detail of the medical history of the patient and the pregnancy. Typically, however, the notes of the attending physician subscribe to the chart's pre-formatted organization. For the June 1914 confinement of Mrs. P.B., a 20 year old Anglican housewife, her attending physician, identified as Dr. Richardson, noted the basic information in the "History Notes" section of the chart:

Para: Primipara
 Began and Ended: Adm. 10:30 a.m. in labor. Delivered 12:35 p.m. June 13th.
 Contraction: Good
 Membrane: Ruptured previous to adm.
 Hemorrhage: normal
 Presentation: vertex
 Position: L.O.A.
 Delivery: Spontaneous
 Laceration: slight
 Cord: normal
 Placenta: expressed 1 p.m.
 Remarks: Conditions of Mother and baby good/ male child/ present Dr. Richardson.¹¹⁴

Apparently, there was no need to record further details about the mother's condition, despite the fact that she was not discharged until June 23 - 10 days after her delivery. However, given the incompleteness of the charts, definitive conclusions cannot be drawn

¹¹⁴ Register Number 4065, *Affections Connected with Pregnancy and Consequences Thereon*, Winnipeg General Hospital. Health Records Department, Health Sciences Center, Winnipeg.

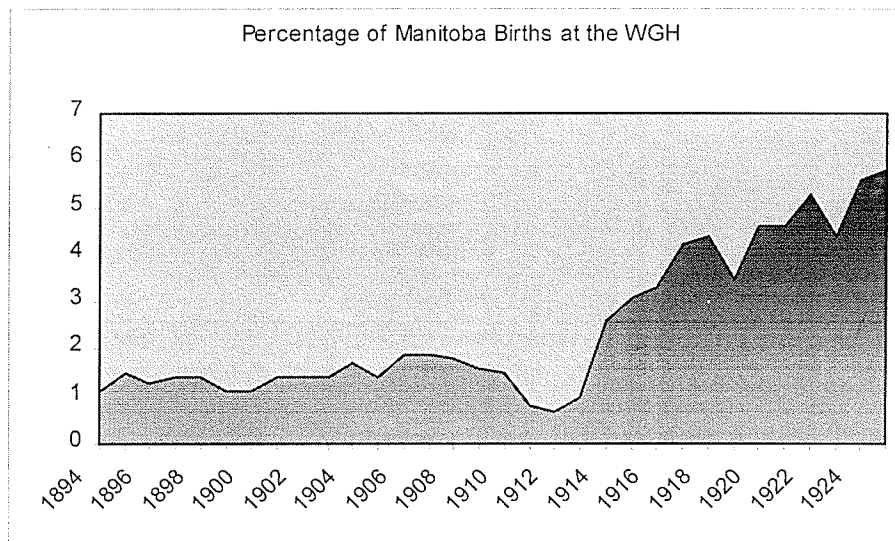
from the sparseness and curtness of recorded information. The standardization of the records do indicate that by 1914 doctors had seen enough in hospital cases to develop a common approach to charting in the Winnipeg General Hospital.

The records of 1914 are more detailed than those from earlier periods, indicating at the least the increased use of medical terminology to describe pregnancy cases. These records furnish some insight into the procedures used by physicians during a typical delivery. Consistent with the circumstances of public ward patients, the majority of mothers were admitted during labour. Care was dispensed by the physician on duty, who typically had minimal knowledge of the patient's health history. The physician used medications and instruments. But what is most noticeable, is that procedures used by physicians in hospital differed little from those used by doctors assisting in home deliveries.¹¹⁵ Even in the sterile and scientific surroundings of the hospital, all that the physician could offer a suffering patient was "strychnine, whiskey, coffee and saline." Still, the number of hospital births increased throughout the 1910's and 1920's. As Chart IV shows, by 1920, approximately 4.5% of births in the province of Manitoba occurred at the Winnipeg General Hospital (approximately 873 births). Winnipeg, at the time, was home to approximately 3% of the province's population.¹¹⁶

¹¹⁵ For descriptions of home delivery practices, see Chapter Fours and Six in this dissertation.

¹¹⁶ Winnipeg's population for 1921 was 179,087, while Manitoba had a population of 610,118. Government of Canada Census, 1921.

Chart IV



Source: Winnipeg General Hospital Annual Reports, 1894 to 1924 and Vital Statistics Agency, Consumer and Corporate Affairs, Government of Manitoba, February 9, 1996.

By the 1920s, the relationship between mothers and the hospital was beginning to change. In January of 1919, a Pre-Natal Clinic was added to the outdoor department where expectant mothers could come to consult physicians, and a nurse would provide regular pre-natal advice.¹¹⁷ In providing regular examinations throughout pregnancy, the hospital was altering the character of care. Traditionally, in-hospital exchanges between doctor and mother were limited to the period of labour, often as a result of complications. In providing pre-natal care in the outdoor department, the hospital was reaching into the homes of poor mothers during their pregnancies and dispersing professional notions of

¹¹⁷ Annual Report, WGH, 1919. PAM MG 10 B11, Box 2. The outdoor department was partially publicly-funded. It provided physician attendance to the poor for non-acute cases.

adequate care and health. More importantly, the Pre-natal Clinic was bringing women into hospital. By 1920, the *Annual Report* noted:

Expectant mothers, many of whom could not otherwise have had attention, have come to the clinic and have been given medical attention and advice. On the whole the women have attended very faithfully. During the year one hundred and twenty-five patients have attended the clinic; of these seventy have come to the Winnipeg General for confinement, several have gone to other hospitals, several have been cared for at home by the Margaret Scott Nursing Mission, and a few have had a midwife in attendance. We have kept in touch with each patient until the birth of her baby, and have made at least one home visit after discharge to those who were confined in the Hospital.¹¹⁸

The business of hospitalized birth was opening with a flourish. Something the hospital was offering appealed to these mothers.

* * *

As physicians learned more about the mechanics of childbirth, the use of the hospital for confinement increased steadily. It was not until the mid-1940s that more than half of all Canadian births occurred in hospital. But the process that brought childbirth to hospital was quite gradual. For much of the period leading up to broad hospitalization, the experiences of women depended as much upon their socio-economic status as it did upon the potential benefits of science. Poor women found themselves in hospital for lack of an alternative. Their presence gave physicians the experience and knowledge they needed to court wealthier families. Through hospital confinement cases, physicians learned standard methods that were applicable to all birth cases, and which accorded them an aura of legitimacy in the birthing room. This acquired validation, coupled with

¹¹⁸ *Winnipeg General Hospital Annual Report* (1920), PAM MG 10 B11, Box 2.

preliminary scientific discoveries, allowed the profession to live up to its promise to provide safer and less painful births.

Chapter 3, Appendix I

TABLE I
Number of Live Births in Canada, Percentage of Canadian Births in Hospital,
1926 to 1973

YEAR	Live Births in Canada	Percentage of Births in Hospital
1973	343373	99.6
1972	347319	99.6
1971	362187	99.6
1970	371988	99.6
1969	369647	99.5
1968	364310	99.5
1967	370894	99.4
1966	387710	99.2
1965	418595	99
1964	452915	98.7
1963	465767	98.3
1962	469693	97.8
1961	475700	96.9
1960	478551	94.6
1959	479275	93.1
1958	470118	91.7
1957	469093	90.2
1956	450739	88.4
1955	442937	86.5
1954	436198	84.6
1953	417884	83.4
1952	403559	81.4
1951	381092	79.1
1950	372009	76
1949	367092	74.3
1948	359860	72.3
1947	372589	71
1946	343504	67.6
1945	300587	63.2
1944	293967	61
1943	292943	54.7
1942	281569	53.7
1941	263993	48.9

YEAR	Live Births in Canada	Percentage of Births in Hospital
1940	252577	45.3
1939	237991	41.7
1938	237091	39.4
1937	227869	36.4
1936	227980	34.5
1935	228393	32.3
1934	228296	30
1933	229791	28.5
1932	242698	27.5
1931	247205	26.8
1930	250335	26.6
1929	242226	24.5
1928	243616	21.5
1927	241149	19.3
1926	240015	17.8

Source: F.H. Leacy, M.C. Urquhart and K.A.H. Buckley, eds. *Historical Statistics of Canada*, first edition. Ottawa: Statistics Canada, 1983, B1-14.

TABLE II

General Statistics, Winnipeg General Hospital, 1888-1925

Year	Number of Patients	Average Stay (Days)	Number of Deaths	Number of Births
1888	840			3
1889	1020	22	82	29
1890	982	25.5	82	46
1891	1133	24.4	64	50
1892	1445	22.5	74	73
1893	1417	21.9	109	63
1894	1572	24.7	99	63
1895	1525	22.4	100	76
1896	1795	21.9	112	74
1897	1977	22.1	116	74
1898	2060	23.7	111	85
1899	2088	21.4	153	69

Year	Number of Patients	Average Stay (Days)	Number of Deaths	Number of Births
1900	2649	20.6	156	70
1901	2773	20.4	177	91
1902	2983	20.2	177	93
1903	2254	18.7	250	109
1904	3868	19.5	271	141
1905	4366	21.5	332	127
1906	4741	24.9	317	181
1907	5113	21.3	387	211
1908	5229	20.5	329	211
1909	5371	19.1	356	201
1910	5935	19.4	405	178
1911	6101	17.5	436	111
1912	5599	16.8	283	108
1913	6105	16.8	348	166
1914	8361	15.9	384	446
1915	9234	15.5	334	553
1916	12590	15.3	436	583
1917	13151	14.7	438	624
1918	13035	13.9	561	667
1919	11919	14.4	499	522
1920	12839	14.8	586	835
1921	12255		508	853
1922	13094	14.9	499	945
1923	9431		375	726
1924	12155	15.9	469	873
1925	13290	16.6	499	860

Source: Annual Reports, WGH. PAM, MG 10 B11, 1888-1925.

Chapter Four

Obstetrical Teachings at the Manitoba Medical School and Medical Perspectives on Childbirth, 1880s to 1920s

Prairie settlement in the second half of the nineteenth century brought numerous trades and professions to the provincial capital of Winnipeg. Among them were a half dozen physicians seeking to establish practices in a burgeoning community.¹ At the time, however, physicians were just beginning to establish themselves as ‘professional gentlemen’. Medicine lacked the aura of professionalism prevalent later in its history. Doctors relied, for the most part, on market demand like any other tradesmen. Historian Harold Perkin has argued that doctors were among an emerging professional class for whom “status rather than market valuation determined their remuneration; their rewards were negotiated in the wider societal market of prestige and the social value placed on their service.”² Physicians were eager to establish themselves. In a bid to establish legitimacy as professionals, they associated with the established institutional structures and organizations, such as hospitals and medical schools. In the process, they began forging a professional guild which suited the needs of medical men.

As the profession established itself, obstetrics developed alongside its contemporary medical educational and institutional specialties. The experience that many doctors acquired in the field of obstetrics came from their association with hospitals throughout

¹ Ronald Hamowy, *Canadian Medicine: A Study in Restricted Entry*. Toronto: The Fraser Institute, 1984, 154. For a description of the apprenticeship approach to medical training and early medical training, see R.D. Gidney and W.P.J. Millar, *Professional Gentlemen: The Professions in Nineteenth-Century Ontario*. Toronto: University of Toronto Press, 1994, 152-54.

² Harold Perkin, *The Rise of Professional Society: England since 1880*. New York: Routledge, 1989, 16.

their careers - as students, interns and later as attending physicians. As has been shown in the previous chapter, however, the obstetrical training received in these institutions was not necessarily comprehensive, nor clinical. Further, despite numerous medical advances in the late nineteenth century - some of which found their way into obstetrical practices - obstetrical education remained relatively unchanged between the mid-1880s and the 1920s.

Through an analysis of medical texts, this chapter will examine the understandings of childbirth which permeated the thinking of educators and students at the Winnipeg General Hospital and highlight the developments which altered the childbirth experience over a 50 year period. A comparison of two texts, William Leishman's *A System of Midwifery* (originally published in 1875) and George Rehberger's *Lippincott's Quick Reference Book for Medicine and Surgery* (originally published in 1920), demonstrates that there were two significant changes in physician attended childbirth: asepsis and anaesthetic. The use of narrative biographies will help illustrate how physicians approached childbirth cases and identify the medical approach in the early twentieth century.³ Lastly, the Manitoba Medical School *Annual Announcement* will provide some context for both the texts and the obstetrical education provided physicians in turn of the century Manitoba.

Most medical work in nineteenth century Canada was general practice; the bulk of which was limited to periods of illness or crisis. As R.D. Gidney and W.P.J. Millar have

³ The memoirs used in this work are published works. While they fall prey to the obvious 'formula' of fiction, they are useful in outlining how physicians saw themselves and their patients.

noted: "Doctors were almost exclusively engaged in the ministering to those already ill, injured or in labour."⁴ Medical education, therefore, predominantly consisted of medicine or 'physic', surgery and midwifery.⁵ Despite some midwifery education, physicians were not necessarily called to the bedsides of parturient women on a regular basis. Jacalyn Duffin has observed that midwifery cases likely only occupied from 6% to 12% of a doctor's practice.⁶ Further, a doctor rarely saw a maternity patient before confinement, and remained only during the delivery.⁷ While physicians had recognized the need for midwifery training, the role of doctors was usually to deal with crisis. The broader notion of maternity care was not included within their professional purview.

The scope of midwifery, therefore, was severely limited in medical education. Generally, medical students obtained little clinical obstetrical experience because their instructors themselves had few opportunities to engage in parturient cases. Despite this limitation, physicians perceived their role in the birthing room as helpful and even imperative.⁸ Their restricted knowledge about the birth process, however, often relegated them to distant observers. They struggled to bridge the gap between belief in their

⁴ Gidney and Millar, *Professional Gentlemen*, 146.

⁵ Gidney and Millar, *Professional Gentlemen*, 154.

⁶ Jacalyn Duffin, "A Rural Practice in Nineteenth Century Ontario: The Continuing Medical Education of James Miles Langstaff," *Canadian Bulletin of Medical History*, 5 (1988), 11. Cited in Gideon and Millar, *Professional Gentlemen*, 146.

⁷ Gidney and Millar, *Professional Gentlemen*, 146.

⁸ For a discussion of the poor obstetrical education of doctors, see Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge, Mass.: Harvard University Press, 1995, 92-110.

science and the very real dearth of knowledge and experience with childbirth attendance. Problems with obstetrical medicine training in the late nineteenth century, lay in the general absence of hands-on experience. While there were parturient patients in hospital, most medical students received only classroom and book training with pregnancy. Access to clinical obstetrical experience for medical students, therefore, was a recalcitrant problem in medical education in the late nineteenth and early twentieth centuries.

Recalling his early days of internship at the Royal Alexandra Hospital in Edmonton in the mid-1920s, Samuel Peikoff, a rural Manitoba physician, confessed his fears about an inadequate education:

I was hoping and praying that the next three months would be more fruitful than my courses in surgery, medicine and pathology. After all, if I am to be a country doctor, I don't need to worry about being able to take out an appendix, but most certainly I will have to know how to handle a confinement. This is a must.⁹

The physician did indeed recognize the importance of childbirth attendance in the formation of his practice. However, as will be shown throughout this chapter, the role of the doctor during a confinement, while perceived as necessary by the profession, was not necessarily that of the central attending figure. Not all women saw the need to call on a physician, and, as has been demonstrated in Chapter Two and will be examined in Chapter Four, not all physicians felt a desire to practice obstetrical medicine.

Peikoff served as a keen example of a physician in training in the first couple decades of the twentieth century; one who struggled with his place at the bedside of expectant mothers. In order to secure sufficient obstetrical training, Peikoff went about

⁹ Samuel S. Peikoff, *Yesterday's Doctor: An Autobiography*. Winnipeg: Prairie Publishing Co., 1980, p. 3.

securing the favour of the head nurse who was responsible for calling the attending physicians and interns to confinement cases in the hospital. In many of the cases, the nurse was the only person in the room with any significant experience, and brushed aside interns or medical students in order to take hold of a precarious situation.¹⁰ Nurses, because of their closer association with women and perhaps because of more attendance at actual births, were likely more knowledgeable than junior physicians.

The image or practice of a nurse pushing aside a doctor, no matter how inexperienced, seems out of context in light of the twentieth century professional hierarchy of the medical community. Yet, in the case of childbirth, the hierarchy was not as distinctly drawn, allowing a degree of leeway for women, whose presence would be a closer approximation to the traditional community of women which surrounded birthing mothers. Many physicians and patients continued to see the physician's role as that of assisting the natural course. The physician's presence was only required at the critical moment of delivery, if at all. The midwife, nurse, or family member, therefore, often had a strong hand in the management of the birth.

Paralleling the ambiguous role of obstetrics in medical practice was an educational curriculum that, while acknowledging the need for childbirth training, nonetheless, did not share Peikoff's impression of the basic relevance of it. Early in the nineteenth century, medical education did include components of midwifery and obstetrics. As early as 1815, a course in obstetrics taught by Walter Channing was a recognized segment of the curriculum at Harvard Medical School. However, the dictates

¹⁰ Peikoff, *Yesterday's Doctor*, 3.

of modesty precluded any man, no matter his profession, from becoming too familiar with a woman. For much of the nineteenth century, therefore, many doctors graduated from medical school never having seen an actual birth.¹¹ The ‘untrained’ midwife often had far more experience and practical knowledge than the physician armed with a medical education.

Why then would physicians find themselves at the bedside of mothers? As discussed in the following chapter, one of the advantages of the physician by the late nineteenth century lay in his arsenal of instruments and anaesthesia which promised an easier, faster and less painful experience.¹² Knowledge of certain medical techniques offered doctors a confidence in the face of childbirth case. That confidence, coupled with the rise of medicine as a profession, was allowing physicians to garner greater authority in situations previously outside their realm of expertise. While little had changed in how physicians actually treated confinement cases in the first 30 years of the twentieth century, the perceptions of the physician’s role had changed drastically.

The development of obstetrics as a medical specialty resulted partially from the professionalization of physicians in the mid to late nineteenth century. In his pivotal 1982 work, *The Social Transformation of American Medicine*, Paul Starr argues that the developments in medical care in the late nineteenth took place within the larger fields of

¹¹ Judith Walzer Leavitt, *Brought to Bed: Child-Bearing in America, 1750-1950*. N.Y.: Oxford University Press, 1986, 41-42.

¹² For a discussion see Leavitt, *Brought to Bed*, ch. 5.

power and social structure.¹³ Doctors sought to manoeuvre themselves into positions of authority. Mechanisms which legitimized the profession (e.g. standardized education, licensing) and those that created patient dependency (e.g. hospitals, health insurance) prescribed a clear structure for doctor-patient relations.¹⁴ “By shaping the patients understanding of their own experience, physicians create the conditions under which their advice seems appropriate.”¹⁵ Doctors were carving a role for themselves in middle-class society. Harold Perkin argues further that the professional class, of which physicians were a part, set out to impose their own visions of society and social mores.¹⁶ In so doing, they were able to design their own positions in society and sculpt for themselves authoritative roles.

In the eighteenth century, and for much of the nineteenth, the physician was marginally included within the realm of the professional classes. One route to a medical career was through apprenticeship, and as such, resembled a learned trade more than a profession.¹⁷ The character of North American society encouraged the care of the sick in the home by family members; physicians' services, therefore, were rarely called upon.

¹³ Paul Starr, *The Social Transformation of American Medicine*. New York: Basic Books, 1982, 8.

¹⁴ Paul Starr, *The Social Transformation of American Medicine*, 20.

¹⁵ Starr, *The Social Transformation of American Medicine*, 14.

¹⁶ Perkin, *The Rise of Professional Society*, 120.

¹⁷ Trade is defined as "a kind of work; business, especially one requiring skilled mechanical work," while profession is defined as "an occupation requiring higher education and a specialized training." Cited in *Dictionary of Canadian English: The Senior Dictionary*. Toronto: W.J. Gage Limited, 1967.

Further, the cost of doctors fees eluded the majority of the population.¹⁸ Physician attendance was seen as a luxury of the wealthy. Health care was perceived as a private matter. Hospitals were a last resort, usually populated by the indigent and the desperate.¹⁹

Doctors themselves were often unable to rely on their medical skills for a complete income and often maintained a secondary occupation. In fact, given the limits of transportation, the cost of attending a case would often exceed the fee. "The price of medical services consists not only of the direct price (the physician's fee, the charge for a hospital room) but also of the indirect price - the cost of transportation (if the patient travels to the doctor or sends another person to summon one and the forgone value of the time taken to obtain medical care".²⁰ As a professional group, physicians were trapped between the "economic liberalism" of *laissez faire* economics and the "social protectionism" of nineteenth century reform ideology.²¹ They were also, as Harold Perkin noted, part of a partnership with other welfare professions which offered an opportunity for influence in society.²²

¹⁸ Starr, *The Social Transformation of American Medicine*, 66.

¹⁹ For a discussion of the evolution of American hospitals see Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*. New York: Basic Books, 1987, chp. 1-3.

²⁰ Starr, *The Social Transformation of American Medicine*, 66. The indirect price was an even greater issue in rural practices.

²¹ Starr, *The Social Transformation of American Medicine*, 61.

²² Perkin, *The Rise of Professional Society*, 344.

Industrialization and urbanization had a significant role in the evolution of medical practice in the second half of the nineteenth century. Adapting to the demands of a market economy, medicine was incorporated into the broader social structure as a recognizable commodity.²³ Improvements in transportation (eg. train, automobile) and communication (eg. telephone) lessened the indirect costs of physician services, and thus put medical care within reach of a wider population.²⁴ Further, increased urbanization created a new patient population for physicians. The migratory population and increased concentration of unattached individuals without family resources drew upon the services of doctors eager to build professional foundations.²⁵ Further, scientific advances - such as bacteriology, antiseptics and anaesthesia - contributed to the authority of medicine as these discoveries emerged over the course of the nineteenth century. The special therapeutic role of the physician, coupled with scientific legitimacy, offered authority within, and outside, the jurisdiction of medicine.²⁶ Ultimately, the elevation of educational standards, the incorporation of medical schools into universities, and the organization of professional groups solidified professional autonomy.

In Canada, this development was clearly evident in the formation of the Canadian Medical Association (hereinafter CMA) in 1867. The CMA marked the beginnings of nationally recognized medical professionalism in the country. The Association, however,

²³ Starr, *The Social Transformation of American Medicine*, 22.

²⁴ Starr, *The Social Transformation of American Medicine*, 71.

²⁵ Starr, *The Social Transformation of American Medicine*, 72-77.

²⁶ Starr, *The Social Transformation of American Medicine*, 4.

did not establish a national licensure law. Individual provinces were left to their own initiatives to develop local licensing laws.²⁷ Ontario was the first province to address the issue by amending the *Ontario Medical Act* in 1868, thereby implementing examination requirements for licensure. By 1874, the Ontario legislature declared it “unlawful for any person not registered to practice [with the College of Physicians and Surgeons of Ontario], profess to practice, or give advice in medicine, surgery, or midwifery.”²⁸

In the late nineteenth century, there was a myriad of lay practitioners offering their services - from midwives to hydropaths - to a public generally unconcerned with provincially-recognized professional qualifications. As a result, the public sought out a variety of health care practitioners. “Until the beginning of the twentieth century, the therapeutic arsenal of clinical medicine remained comparatively primitive and the distinction between professionally trained and less well-trained educated practitioners was small.”²⁹ In 1876, the Province of Ontario had appointed a special prosecutor in response to physicians’ claims that eclectics and hydropaths were endangering public welfare.³⁰ However, the impact of a single individual on the large number of alternative practitioners was likely minimal. Ultimately, each province established licensure laws

²⁷ Hamowy, *Canadian Medicine*, 97.

²⁸ Hamowy, *Canadian Medicine*, 118-19.

²⁹ Hamowy, *Canadian Medicine*, 125.

³⁰ Hamowy, *Canadian Medicine*, 123.

under the direction of individual Colleges of Physicians and Surgeons. But it was not until the very end of the century that physicians gained a professional monopoly.

Shortly after the incorporation of the Province of Manitoba in 1870, preliminary steps were taken to ensure solidification of the medical profession in the province. *An Act Relating to Medical Practitioners in this Province* (1871) established the first provincial medical board. The Board, composed entirely of medical men, outlined the requirements for licensure and set examinations for those wishing to practice medicine in Manitoba.³¹ In order to qualify to take the exam, an applicant had to have taken courses in general anatomy and physiology, practical anatomy, surgery, medicine, midwifery, chemistry, materia medica and pharmacy. Further requirements included a minimum of twelve months general practice attendance in a hospital, with six month courses in both clinical medicine and clinical surgery.³² The *Act* also empowered the Board to regulate the practice of irregulars by imposing a heavy fine on those found practicing without a valid Manitoba medical license: "If any person practice Physic, or Surgery, or Midwifery, in Manitoba, contrary to the provisions of this Act, he shall hereby incur a penalty of Twenty dollars for each day on which he so practices, and such penalty shall be

³¹ Ross Mitchell, *Medicine in Manitoba: The Story of Its Beginnings*. Winnipeg: Stovel-Advocate Press, Ltd., 1954, 56. *An Act Relating to the Medical Practitioners of this Province*, (hereafter *Manitoba Medical Act*), Chp. XXVI, 2nd session, First Parliament, 34th Victoria, 1871.

³² Section 12, *Manitoba Medical Act* (1871)

recoverable on the oath of any two credible witnesses.”³³ Under the *Act*, it was the medical men who controlled the types and number of practitioners in the province.

The founding of the College of Physicians and Surgeons of Manitoba in 1877 bolstered professional authority in the province. The legislation enabled the College to “conduct preliminary examinations of medical students within Manitoba, to establish a tariff of fees for the province, and to levy an annual tax of not more than five dollars on each registered physician.”³⁴ The original targets of the stiffer requirements were American graduates who funneled into the province from a myriad of U.S. private schools. The first register of the College, listing licensees from 1874 to 1882, records a total of 48 physicians, only three of whom held degrees from American schools.³⁵

Looking over the names associated with the chief medical institutions in Manitoba, it is apparent that a handful of physicians were primarily involved in the professionalization and institutionalization of medicine in the province. Twenty-one of the original members of the College are listed as staff at the Winnipeg General Hospital between 1884 and 1895.³⁶ The involvement of the physicians with both institutions was partially attributable to the relatively small size of the community. However, the

³³ Section 7, *Manitoba Medical Act* (1871)

³⁴ Hamowy, *Canadian Medicine*, 155.

³⁵ Hamowy, *Canadian Medicine*, 155.

³⁶ See Mitchell, *Medicine in Manitoba*, 57 and *Winnipeg General Hospital Annual Report*, 1884 to 1895. PAM MG 10 B11, Box 1.

involvement of the same individuals at both was indicative of the development of a medical elite in the city.

These same physicians were also instrumental in founding Manitoba's only medical school, the Manitoba Medical College, in 1883. The College started at the instigation of local physicians who were opposed to the proposed establishment of a private medical school, and sought recourse through a government supported institution.³⁷ Through affiliation with the University of Manitoba (established 1877) and the College of Physicians and Surgeons of Manitoba, the Medical School was empowered to conduct license examinations in conjunction with the curriculum. "Towards this end, the University Council could conduct examinations and set the preliminary and professional educational requirements necessary for registration."³⁸ Consequently, any competing medical schools would effectively be unable to provide access to licenses for its graduates, and thus were squeezed out of the market.

Despite the initial fervour to establish a school in the province, the actual opening was haphazard. When the first term began in 1883, the school had no facilities, no curriculum, no faculty, and no dean. Classes were held in a local high school by the physicians who pushed to incorporate the institution. In reality, those involved had not

³⁷ N. Tait McPhedran, *Canadian Medical Schools: Two Centuries of Medical History, 1822 to 1992*. Montreal: Harvest House, 1993, p. 140.

³⁸ Hamowy, *Canadian Medicine*, 156.

intended to start up immediately, but rather sought only to curtail the involvement of non-medical personnel in medical education.³⁹

In its first full year of operation, 1884-85, the Manitoba Medical School registered 15 students for lectures in Anatomy, Practical Anatomy, Physiology, Chemistry, Materia Medica and Therapeutics, Surgery, Medicine and Obstetrics for a cost of \$15 per student. Obstetrics was indeed recognized as a core component of medical training. However, as one contemporary physician noted: “The subject of obstetrics was from the beginning and for many years the despised sister, the Cinderella of any medical curriculum.”⁴⁰

Additional courses could be taken in Clinical Medicine and Surgery, Practical Chemistry and Medical Jurisprudence for \$6, or Botany and Sanitary Science for \$5.⁴¹

By 1885, a two story building had been constructed to house the school and James Kerr had been elected dean. A student completing the curriculum was obliged to:

lodge with the Registrar documentary evidence that he is of the full age of 21 years; that he has pursued medical studies for the period of at least four years, and has attended lectures for three sessions of six months each in the following branches of Medical Education, for the respective period hereinafter set forth, in some University College or School in Her Majesty’s Dominions recognized by the University of Manitoba.⁴²

³⁹ McPhedran, *Canadian Medical Schools*, 140-41.

⁴⁰ W.W. Chipman, “Symposium on Obstetrics - Some End-Results,” *CMAJ* 16 (June, 1926): 681.

⁴¹ See Manitoba Medical College, *Annual Announcement of the Second Year Session, 1884-85*. Neil John Maclean Health Sciences Library Rare Book Room, University of Manitoba, Bannatyne Campus. Classes formally began on November 1, 1883. However, there was no building or administrative structure for the school until 1884-85.

⁴² Manitoba Medical College, *Annual Announcement of the Second Year Session, 1884-85*.

Further, the student was expected to have acquired eighteen months of practical experience in an incorporated general hospital, attended two sessions of clinical bedside instruction and have had at least six months practice in a lying-in hospital with attendance at a minimum of six labour cases.⁴³

While six months practical experience seemed an acceptable amount of time, the overall requirement deserves closer examination. The *Announcement* did not stipulate whether the student was to attend as an observer or participant in the process. In fact, it failed to provide any specific clinical expectations. Despite being associated with a lying-in hospital for six months, physicians in training were expected to attend only six confinements. This suggests that either practice in a lying-in hospital was less than full-time, or the number of patients in the lying-in hospital during a six-month tenure was small. Either way, after meeting the requirements, students' exposure to childbirth appeared to remain fairly minimal.

The obstetrical training of physicians was based more on class room instruction than practical experience. As Charlotte Borst has shown in her study of the evolution of childbirth attendance in Wisconsin, prior to 1905, there was little by way of clinical obstetrical experience for student physicians.⁴⁴ In fact, contemporary studies of medical education harshly criticized the obstetrical components in medical schools. The well-known Flexner Report (1910) singled out obstetrics in its review of medical educational

⁴³ Manitoba Medical College, *Annual Announcement of the Second Year Session, 1884-85*.

⁴⁴ Borst, *Catching Babies*, 92-104.

standard across the United States, stating that lectures were “utterly worthless”.⁴⁵ The obstetrical educational techniques used in Canadian schools - lectures and demonstrations on manikins - were very similar to those under criticism the United States. The obstetrics component of training at the Manitoba Medical School was a requisite in the final year. It involved a combination of course work with some practical experience. The course, prepared by R.B. Fergusson, was taught in conjunction with diseases of women and children. Linking obstetrical specialties with pediatric medicine was not an uncommon practice. Often physicians specializing in the diseases of children would become involved in the health care of women as well.⁴⁶

The Manitoba Medical School’s *Annual Announcement* described the obstetrics course. It was organized around five lectures a week throughout the term, illustrated by models, plates and prepared specimens. The course followed a very specific outline which paralleled the chronology of childbirth.⁴⁷ Instruction focused on the anatomy of pregnancy and the mechanics of delivery:

I. Anatomy of the Female Pelvis and Foetal Head; Anatomy of Organs of Generation.

II. Parturition - (1) Natural Labour; its general phenomena; Mechanism of Labour; Management of Natural Labour; Anaesthetics

⁴⁵ Cited in Borst, *Catching Babies*, 106.

⁴⁶ This was especially the case with women physicians, such as Dr. Helen McMurchy, who began her private practice caring for women and children.

⁴⁷ Manitoba Medical College, *Annual Announcement of the Second Year Session, 1884-85*.

(2) Unnatural Labour; (a) From abnormal condition of the uterus, soft parts or bony pelvis. Treatment of these abnormal conditions. Use of forceps; Craniotomy; Turning.

(3) Complex Labour; Retained Placenta; Uterine Haemorrhage; Puerperal Convulsions; Puerperal Fever

III. The Puerperal State⁴⁸

In the lectures, students were verbally carried through a delivery. Instructors often had the assistance of mostly hand-drawn images and relied on textbook to provide more illustrative information. The drawings themselves did not necessarily subscribe to Victorian notions of modesty, and offered fairly graphic renderings of the pregnant female form. In his obstetrical notebook, McGill obstetrician J.C. Cameron provided physiological drawings beside patient charts which demonstrated the pathway of the foetus, and allowed the practitioner to graphically describe any abnormalities.⁴⁹ Nonetheless, these drawings were a distant second to any clinical hands-on experience. After the completion of lectures, students were placed on the wards of a lying-in hospital to acquire whatever experience possible.

An examination of the required texts for the course offers some understanding of the medical perceptions of childbirth at the Manitoba Medical School, and, by association, at the Winnipeg General Hospital. The two texts listed for the obstetrics course in 1886-87 were William Leishman's *A System of Midwifery* (1875), published in the United States, and William Playfair's *A Treatise on the Science and Practice of*

⁴⁸ Manitoba Medical College, *Annual Announcement of the Second Year Session, 1884-85*.

⁴⁹ J.C. Cameron, *McGill obstetrical note book*. Montreal: E. Renouf, 1896. University of Ottawa, microfiche, CIHM No. 02285.

Midwifery(1884), published in Britain. Both appear to have been familiar to the medical community as evidenced by the curt bibliographic references listed in the *Annual Announcement*, which simply read: “Playfair's or Leishman's *Midwifery*.”⁵⁰

The titles of the texts illustrated medicine's attitude towards childbirth attendance in the late nineteenth century. While the word ‘midwifery’ remained prominent, suggestive of the traditional notions which still clung to childbirth attendance, both physicians adopted scientific descriptions, such as ‘system’, ‘science and art’, suggesting a more scientific approach. Within the pages of his 1875 text, William Leishman eschewed traditional definitions of midwifery implied by the French *accouchement* and the German *geburtshilfe*. His description was as “the Science and Art, which has for its object the management of woman and her offspring during Pregnancy, Labor, and the Puerperal State.”⁵¹ The use of the term ‘management’ is laden with meaning. The physician felt himself to be the authority in the birthing room, despite evidence that physicians were often marginal figures during confinement attendance.

More broadly, the term management was indicative of the social ideals being espoused by the emerging professional class. The concept of professional ‘management’ surfaced among business professionals. At the turn of the twentieth century, they were dealing with increasingly complex industrial organizations which required skilful

⁵⁰ Manitoba Medical College, *Annual Announcement of the Fourth Year Session*, 1886-87.

⁵¹ William Leishman, *A System of Midwifery*, second edition. Philadelphia: Henry C. Lea, 1875, 33.

direction. The science of management, however, was not restricted to private industry.⁵² As medical treatment became increasingly more involved, the trained professional's role was to draw on his skill and expertise to align knowledge and practice in the care of patients. It was not a surprise to see physicians import similar concepts used by other professional groups who shared similar socio-economic standing.

In preparing physicians for their 'managerial' roles in the birthing room, the medical texts laid out a very specific, detailed and chronological approach to treatment. The first concern of the physician faced with a pregnancy case was to determine whether or not the patient was indeed with child:

We can conceive of no subject to which a mistake might so utterly ruin a young man's hopes, than the determination, in delicate and doubtful cases, of this question of pregnancy. An obvious pregnancy overlooked, because the idea has never crossed the mind, is bad enough . . . But what is far more inexcusable, is the culpable rashness of those who, without irrefutable evidence of the existence of pregnancy, would venture - as has been done in high quarters - to brand a woman with the stigma of dishonor.⁵³

The words illustrate the commonly held notion that women were responsible for conception.⁵⁴ Pregnancy, overt evidence of a sexually active woman, was perceived to be a dishonourable predicament, an embarrassing medical condition that should be hidden if possible. A real diagnosis would be bad enough, but to falsely diagnosis a pregnancy carried a 'stigma of dishonour', not for the physician, but the woman.

⁵² Perkin, *The Rise of Professional Society*, 24.

⁵³ Leishman, *A System of Midwifery*, 149-50.

⁵⁴ Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918*. New York: Oxford University Press, 1993, 99.

The text, therefore, clearly listed signs of pregnancy; a catalogue of symptoms by which the physician was to guide his examination. Some symptoms were considered certain, while others were interpreted as merely suggesting pregnancy. Cessation of menses, morning sickness, increased salivation, changes in the mammae and appearance of abdomen were considered potential indications of pregnancy. According to Leishman's text, there were three certain diagnostic signs of pregnancy.⁵⁵ The first sign, quickening, was determined by the mother, as it was the point at which she felt fetal movement.⁵⁶ The other two, ballottement and fetal pulsation, involved the physician. For ballottement, the physician applied a sharp jerk upwards with the finger to the uterus. The foetus rose in the amniotic fluid, and then floated back down to the tip of the finger.⁵⁷ Fetal pulsation, or the identification of the fetal heartbeat, was particularly grounded in the principles of medicine. The development in the early 1800s of the stethoscope gave doctors the same ability as the mother. Both were able to identify the presence of the fetus; the mother through movement, the physician through science. As historian Jacalyn Duffin noted: "with auscultation, the doctor's objective indicator could bypass the mother's perception of movement."⁵⁸

⁵⁵ Leishman, *A System of Midwifery*, 149-50.

⁵⁶ Quickening is usually noted in the fourth or fifth month of pregnancy. See *Stedman's Medical Dictionary*, 21st edition. Baltimore: The Williams and Wilkins Co., 1966, 1341.

⁵⁷ Leishman, *A System of Midwifery*, 149-50.

⁵⁸ Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction*. Toronto: University of Toronto Press, 1999, 254.

It is interesting to note that in the absence of any definitive test to determine pregnancy, the same signs were listed fifty-five years later in a 1930 edition of *Lippincott's Quick Reference Book for Medicine and Surgery*. The only difference was the way in which the symptoms were classified. Leishman's list had been organized in order from the potential indicators, such as morning sickness, to the more definitive signs, such as ballottement. Lippincott, on the other hand, presented the symptoms in the order they occurred during the advancement of pregnancy.⁵⁹

Once the diagnosis of pregnancy was determined, the physician's role changed to that of a mere attendant. Members of the medical profession were, for the most part, at the mercy of nature when it came to childbirth management. "In a very large proportion of all cases," Leishman noted, "the various stages of labor are effected by the unaided efforts of nature, in a manner which renders any "assistance" on the part of the accoucheur . . . quite unnecessary."⁶⁰ Authoritative texts were unable to say with any certainty what brought on the onset of labour and thus, physicians, like the mother, waited. The chief role of the medically-trained birth attendant was to watch for any inconsistencies that would represent a deviation from the normally-perceived course of the birth. Manitoba Medical School students read that "it is only . . . by the careful study of the normal process, that it is possible for us to recognize speedily and with precision

⁵⁹ George E. Rehberger, *Lippincott's Quick Reference Book for Medicine and Surgery*, Seventh Edition. Philadelphia: J.B. Lippincott Co., 1930.

⁶⁰ Leishman, *A System of Midwifery*, 268.

deviations from the physiological standard.”⁶¹ The recognition of the abnormal was the justification for the presence of the physician, even though most of the duties required of a childbirth attendant “might, in nineteen cases out of twenty, be performed as efficiently and perhaps more agreeably to the feelings of the patient by a thoroughly trained and intelligent nurse.”⁶² The student’s textbook recognized the fact that obstetrical work was often looked on with “disdain” by medical professionals. It warned students that in many cases the “practice of the great majority of professional men extends, more or less, in directions where he has himself to discharge many of the duties which are more properly those of the nurse.” The physician’s role, however, was to be able to perform these same duties because dangers and complications could arise so suddenly that only the physician had “the skill requisite for the management of even the more remediable complications of midwifery.”⁶³

The irony of the situation was that newly-trained physicians claimed authority in the birthing room based on limited knowledge of the mechanics of birth. Students were encouraged to study the text, and the normal procedures of labour, but were offered very little experience with real obstetrical situations. Faced with the onset of labour, for example, the physicians’ text could no more attest to the causes of labour than midwives or mothers:

⁶¹ Leishman, *A System of Midwifery*, 269.

⁶² Leishman, *A System of Midwifery*, 268.

⁶³ Leishman, *A System of Midwifery*, 269.

Whatever we assume the causes of labor to be, the immediate effect of its operation is to rouse the latent energy of certain Forces, by means of whose active co-operation the delivery of the woman is affected. The prime force, to which the others are merely subsidiary, is, as is well known, the contraction of the muscular fibres of which the uterus is, to a large extent composed.⁶⁴

The vague language used in the textbook provides the reader with a detailed description of labour, but little in the way of causal analysis useful for diagnosing it. The process of childbirth was a mystery to both doctor and mother.⁶⁵ Nonetheless, physicians did differ themselves from midwives by claiming greater knowledge of the birthing process than traditional midwife attendants. According to Leishman, it was important for the physician to have knowledge of all the basic duties associated with parturition, so that he “may be able to detect incompetency, and to remedy its defects.”⁶⁶ This apparent knowledge made physicians the preeminent authority, despite their lack of actual experience.

The psychological aspects of the birth process was another area where physicians espoused authoritative understanding. In writing about “Labour and its Phenomenon”, Leishman sought to warn about the influences which may bring about labour:

Sudden mental emotion of any kind may, by augmenting the force or frequency of the expulsion action, sometimes influence the progress of labor in a marked degree; and this has been observed to occur upon the threat of using instruments, or upon the exhibition of the forceps. Causes,

⁶⁴ Leishman, *A System of Midwifery*, 254.

⁶⁵ It should be noted that the actual causes of natural labour are still unclear, thus the prediction of delivery is still an inexact calculation.

⁶⁶ Leishman, *A System of Midwifery*, 269.

then, which being psychical, have their origin in the cerebrum, may act either by increasing or by arresting the uterine effort.⁶⁷

As Leishman's warning indicated, medical students were instructed to make use of the mother's conscious and unconscious cognitive control during childbirth. The implication was that the doctor, because of his familiarity with the psychosomatic connection, could influence the course of labour by playing with the patient's emotions. Leishman was aware of the intrusion physicians represented in the birthing room:

Certain emotional causes produce an effect on the uterine contractions which is not easy to account for. Few occurrences are more familiar to the accoucheur than the effect his arrival frequently produces upon the progress of labor, by causing a complete temporary cessation of all uterine effort.⁶⁸

The physicians's psychological role in the management of labour was heavily impressed upon students through the educational curriculum. Leishman's text taught students that their comportment in the birthing chamber would have a significant influence on the emotional state of the mother, and therefore an impact on the course of labour. In discussing the first stage of labour, he conveyed the importance of occupying the mother's attention:

If she can be induced to occupy her attention, as far as possible, by any familiar occupation, however trivial, it will be to her advantage, by relieving the tedium of her suffering. If this cannot be done, her attendants should try, by cheerful conversation to beguile the time, and to divert her mind from the gloomy apprehensions which are of frequent occurrence at this period. The accoucheur should not remain in the room during this stage unless there be any special necessity for it, although he may visit occasionally. To do otherwise would encourage her to expect assistance at

⁶⁷ Leishman, *A System of Midwifery*, 254.

⁶⁸ Leishman, *A System of Midwifery*, 254.

his hands, which it is not in his power to afford; and, moreover, his presence would to her seem to imply that he expected a speedy termination of her sufferings.⁶⁹

Drawing a clear line between the worlds of medicine and simple midwifery, Leishman preached that the physician's presence would have a greater impact on the mother than her attendants, despite the fact that one of those attendants may have been a midwife.

The physician's belief in his own authority is superimposed upon the emotions and psychological condition of the mother. While the mother may have indeed anticipated that the physician's presence meant a swift termination of her suffering, the expectation was encouraged by the doctors' reluctance to remain in the room until absolutely necessary. Unlike midwives and traditional attendants, doctors were counselled to be in the room only for the 'medical' part of the delivery.

The first role of the attending doctor upon arriving in the birth chamber was to examine the mother. Such a practice would certainly have been considered loathsome by most nineteenth century women. Students were taught the dictates of prototypical Victorian modesty when approaching female patients, a decorum that was reinforced in obstetric work. When proceeding with a vaginal exam, students were warned:

We should never forget the consideration which is due to the feelings of the patient, whatever her rank in life. For it cannot be otherwise, than that a woman must look upon such an examination as is necessary, by a person of the opposite sex, with apprehension, if not with abhorrence; but if the necessity be first explained to her in a few kindly words, she will rarely fail to appreciate the good feeling which prompts them, and will submit

⁶⁹ Leishman, *A System of Midwifery*, 273.

without a murmur to whatever may be deemed essential to her safety or comfort.⁷⁰

Medical schools taught young physicians not only the proper etiquette for approaching patients, but also prescribed the acceptable attitudes of their patients. The implication was that women faced with the prospect of such an examination should be loath to submit. It was up to the physicians to properly explain the necessity. Once he had brought the weight of science and reason to bear, the patient would dutifully obey. The delicately-negotiated nature of the doctor-patient relationship was therefore reinforced in the birthing room where the mother was treated more like a sick invalid, than the matron of the family. In making childbirth a medical condition, the traditional dynamic of the birth experience was altered by the influence of medical culture. A physician's presence, by the very nature of this relationship, undermined the maternal position.

The process of the examination would have been somewhat abhorrent to a late-Victorian middle-class woman. However, it was not necessarily with middle- or upper-class patients that physicians received hands-on training in physical examinations. Rather, it was more likely in the hospitals and the homes of the poorer patients seeking access to medical treatment. The intrusive nature of a prescribed medical exam would have probably limited the class of patient that submitted to such an exam:

The woman lies on her left side, with her back to the examiner, and the near edge of the bed, which must, if necessary, be previously arranged as to admit of this. The index and middle finger of either hand . . . being then smeared with lard or oil, are passed over the perineum, and gently into the

⁷⁰ Leishman, *A System of Midwifery*, 270.

vagina up to the os uteri. It is usual to select a period of pain for the examination.⁷¹

Leishman's description underscores the potential affront to Victorian modesty in a typical exam.

The objective of the examination was to determine whether the vagina was soft, relaxed and lubricated, ensure the *os uteri* was sufficiently malleable and dilatable, check the membranes, confirm natural presentation, ascertain the presence of any pelvic deformities and recognize early any potential difficulties with the cord.⁷² Students were discouraged from attempting too many pelvic exams. There was, however, no specific mention that students should wash their hands prior to the exam. In an apparent contradiction to rigid asepsis, it was suggested that the physician lubricate his hands with "some bland lubricate".⁷³ The illustrative drawing in the text, showing an un-gloved hand entering through the vagina and touching the uterine wall, also contradicted the techniques of asepsis. This practice would certainly encourage the spread of sepsis infection, especially in a hospital environment where doctors moved between cases with relative ease.

The diagnostic and examination techniques changed little between the 1880s and the 1920s. Although, the profession's greater commitment to the precepts of asepsis was detectable in the later texts. Initially published in 1920, *Lippincott's Quick Reference*

⁷¹ Leishman, *A System of Midwifery*, 271.

⁷² Leishman, *A System of Midwifery*, 272.

⁷³ Leishman, *A System of Midwifery*, 273.

Book's description of aseptic techniques in the conduct of normal labour cases were unmistakable:

As soon as bearing down pains appear, make preparations for delivery. Place on a table at the side of the bed a basin with warm bichloride solution, 1:2000 (which may contain sterile gloves, a gauze sponge, cotton pledgets, boric acid solution in a glass, sterile towels, sterile safety pins, bobbin or tape for tying the cord, curved needles, needle-holder, silk-worm-gut, catgut, scissors (plain and umbilical), artery clamps, long dressing forceps, tenaculum forceps, and vaginal speculae. Cleanse the genitalia with soap and water followed by bichloride solution, and apply compresses wet with the latter. Disinfect the hands. As soon as the head can be palpitated through the perineum place at least four sterile towels about the vulva, one beneath the buttocks, and pin them in place.⁷⁴

The emphasis on a sterile environment around the mother and the importance of disinfection were evident. The language used in *Lippincott's Quick Reference Book* demonstrated the profession's allegiance to septic theory, and represented a difference in how childbirth was managed by the 1920s.

In his text, Leishman outlined three distinctive stages of labour. As has been shown, during the first stage, beginning at the onset of labour pains and terminating with the complete dilatation of the *os uteri*, the physician performed a digital examination and tried to calm the mother.⁷⁵ The second stage was the actual expulsion of the baby. The final stage was the separation and delivery of the afterbirth.⁷⁶ With the onset of the

⁷⁴ Rehberger, *Lippincott's Quick Reference Book*, under "Conduct of Normal Labor", no page number. Bichloride is a compound containing two atoms of chlorine to one of another element used as a disinfectant.

⁷⁵ "Os uteri" is defined as "the mouth of the womb; the vaginal opening of the uterus" in *Stedman's Medical Dictionary*, 1151.

⁷⁶ Leishman, *A System of Midwifery*, 257.

second stage of labour, the mother effectively disappeared in Leishman's text. Rather, the emphasis rested on the mechanics of the birth process and the anatomy of the female reproductive tract. The only mention of the patient as an entire person was when the author noted:

The ordinary night-dress which the patient wears, or rather that part of it which is beneath her as she lies, should be rolled up above the waist, and the lower part of the body covered with a petticoat which opens all the way down, and she should then be covered with such bedclothes as the season of the year and her own feelings may render necessary.⁷⁷

The mother was then placed on her left side with her back to the physician so that he might prepare instruments without disturbing her. Questions of pain, safety and ease were related directly to the doctor's role, rather than the patient's ease and comfort. Leishman made no mention of monitoring the mother's condition, nor did he elaborate on means of assisting the mother emotionally, as had been done in discussions on the first stage of labour. In Leishman's description, rather, the focus is on the perineum, not the patient:

The proper management at this stage - which will be found to be attended with results of the most satisfactory kind - consists in watching the amount of pressure to which the perineum is being subjected. This may be done effectively and easily by keeping a finger on the anterior margin of the perineum, which enables us, with little practice, to gauge with tolerable accuracy the degree of propulsive force which is being exercised. Should this exceed the normal standard, so as to imperil the integrity of the tissues, we must then order all aids to expulsive effort to be removed from the reach of the patient, and at the same time encourage her to cry out

⁷⁷ Leishman, *A System of Midwifery*, 274.

lustily during the height of pain, or, in other words, to make free use of the safety-valve of the glottis.⁷⁸

The tone used by Leishman was clinical. It gave the impression of a mechanical device which required the dissemination of pressure to prevent breakage. The patient remained in the description, but not as a woman or a mother, but rather as a condition requiring curative treatment. The medicalized description of childbirth removed the patient in favour of the symptoms, and thus subjected parturient women to a prescribed code of behaviour and expectations.

One of the biggest changes in Lippincott's later text was the introduction of pharmaceutical aids to hurry, prolong or ease labour. During the first stage, the mother was cautioned not to bear down and encouraged to relax. Chloral, morphine or scopolomine could be offered to hasten the dilatation of the cervix and alleviate further suffering.⁷⁹ At the indication of the commencement of the second stage, the patient was to be bed-ridden and whiffs of ether and chloroform could be administered during extreme pains.⁸⁰ Rehberger's description was much more clinical than his predecessor's, and included the liberal use of anaesthetic :

⁷⁸ Leishman, *A System of Midwifery*, 279. The perineum is the "external surface or base of the perineal body, lying between the vulva and the anus in the female." In *Stedman's Medical Dictionary*, 1204.

⁷⁹ Choral likely refers to chloral hydrate which "occurs in colourless transparent crystals, with an aromatic and slightly acrid odor and a slightly bitter caustic taste, soluble in water and alcohol. Hypnotic, sedative, and anticonvulsant. Used externally as a rubefacient, anesthetic, and antiseptic." In *Stedman's Medical Dictionary*, 306.

⁸⁰ Rehberger, *Lippincott's Quick Reference Book*, "Conduct of Normal Labor" no page number.

Begin to use chloroform or ether, giving it only during pains, as soon as the head begins to distend the vulva. When the head begins to emerge from the vulva, push the chloroform to complete anaesthesia . . . Do not pull upon the child . . . As soon as the child is born, apply the hand to the abdomen and see, by pressure and kneading, that the uterus remains contracted.⁸¹

The afterbirth was to be examined for any missing portions and ergot administered to the patient. The mother was cleansed with bichloride solution and sterile pads applied to the vulva. The doctor was instructed to remain with the patient for at least one hour to assure the uterus remained in tact.⁸² Both *Lippincott's Quick Reference* and Leishman recommended "Credé's method" to assist the expulsion of the placenta. This technique involved "squeezing the placenta and membranes out of the womb"⁸³ in the same manner "as one would squeeze a lemon."⁸⁴ With that remarkably domestic task over, the physician's perceived role in the birthing room from the 1880s and the 1920s was effectively over.

Beyond the mechanics of the actual birth, both texts had prescriptions for the post-partum period. Unlike the physical descriptions quoted above, the diagnoses of patients' mental conditions are fraught with socio-cultural values and significance. Leishman's

⁸¹ Rehberger, *Lippincott's Quick Reference Book*, "Conduct of Normal Labor," no page number.

⁸² Rehberger, *Lippincott's Quick Reference Book*, "Conduct of Normal Labor," no page number.

⁸³ Leishman, *A System of Midwifery*, 281.

⁸⁴ Rehberger, *Lippincott's Quick Reference Book*, "Conduct of Normal Labor," no page number.

chapter on puerperal insanity⁸⁵ provides a clear example of the social constructs of medicine that surrounded the birth experience. In his pivotal study of insanity in the age of reason, philosopher Michel Foucault has argued that the recognition of madness had as much to do with society's beliefs, as it did with any legitimate diagnosis. "Madness deals not so much with the truth and the world," wrote Foucault, "as with man and whatever truth about himself he is able to perceive."⁸⁶ American historians Carroll Smith-Rosenberg and Charles Rosenberg have applied a similar assumption to their study of medical views of women in the nineteenth century. The Rosenbergs contend that physicians "employed medical and biological arguments to rationalize traditional sex roles as rooted inevitably and irreversibly in the prescriptions of anatomy and physiology."⁸⁷ More recently, Canadian historian Wendy Mitchinson has drawn these two arguments together, arguing that "gender played a significant role in how physicians assessed symptoms of insanity."⁸⁸ The diagnosis of puerperal insanity, rooted in the socio-cultural beliefs about women and gender roles, had an element of the subjective, and therefore allowed the physician greater leeway in determining etiology and treatment.

⁸⁵ Leishman distinguishes between "puerperal insanity" and "the insanity of pregnancy". Puerperal insanity is the diagnosis used in the post-partum state, while insanity of pregnancy refers to altered characteristics which carrying.

⁸⁶ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*. New York: Vintage Books, 1988, 27.

⁸⁷ Carrol Smith-Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century American," *Journal of American History*, 60 (Sept., 1973), 332.

⁸⁸ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1991, 313.

Puerperal insanity, defined as mental aberrations in the puerperal state, was the diagnosis ascribed to women who were melancholic or exhibited erratic behaviour following childbirth. Symptoms included ill-temper, fretfulness, capriciousness, less control over emotional faculties, tearfulness or excessive laughter, perverted sense of smell or taste and generally behaviour “different in disposition from what had hitherto been her individual characteristics.”⁸⁹ The etiology of the condition was unknown and according to contemporary theory was more prevalent in women who had endured repeated pregnancies in short intervals. On the same token, “unmarried women, [who felt] deeply the degradation of their position, [were] much more susceptible than others.”⁹⁰ The very diagnosis was based on a physician’s perception of what constituted normal behaviour for a woman.

For Leishman, puerperal insanity was distinguished by two classifications: mania and melancholy. Mania was believed to be the most prevalent form of post-partum dementia and was characterized by a host of symptoms, most of which were attributable to any diagnosis of insanity:

In mania, there is almost always, at the very commencement, a troubled, agitated, and hurried manner, a restless eye, an unnaturally anxious, suspicious, and unpleasing expression of face; sometimes it is pallid, at others more flushed than usual; - an unaccustomed irritability of temper, and impatience of control or contradiction; a vacillation of purpose, or loss of memory; sometimes a rapid succession of contradictory orders are issued; or a paroxysm of excessive anger is excited about the merest trifle.

⁸⁹ Leishman, *A System of Midwifery*, 658.

⁹⁰ Leishman, *A System of Midwifery*, 659.

Occasionally, one of the first indications will be a sullen obstinacy, or listlessness and stubborn silence.⁹¹

As the illness progressed, the patient was said to become paranoid, delusional and potentially suicidal.

The symptoms described were conspicuous in that they had no apparent physical manifestation. In fact, they were only recognizable in that the patient exhibited behaviour perceived as uncharacteristic. Leishman's citation of a Dr. Ramsbotham reinforced this conclusion when he noted: "One peculiarity attending some cases of puerperal mania is the immorality and obscenity of the expressions uttered; they are often such, indeed, as to excite our astonishment, that women in a respectable station of society could ever have become acquainted with such language."⁹² In other words, cursing was assumed to be an indication of severe dementia when associated with a post-parturient woman. This particular symptom, however, may only have been considered an indication of illness if the outward character of the patient was not normally disposed to uttering foul language. Had a poor, uneducated woman exhibited the same behaviours, a physician may not have considered it a sign of illness.⁹³ Socio-economic expectations were indeed rooted in diagnostic techniques.

⁹¹ Leishman, *A System of Midwifery*, 663.

⁹² Leishman, *A System of Midwifery*, 664.

⁹³ Barbara Enrenreich and Deirdre English, *For Her Own Good: 150 Years of Experts' Advice to Women*. New York: Anchor Books, 1979, 112-13.

Melancholy was diagnosed less often in cases of puerperal insanity, being more often ascribed to women during pregnancy. The symptoms described by Leishman echo more modern descriptions of post-partum depression:

Perhaps a month after the birth of the child, a change comes over the mother, which, to her attendants, is quite inexplicable. The pride and interest in a firstborn child gradually fades away, and a cloud of sadness, utterly without cause, slowly spreads itself over the aspect and demeanor of the mother.⁹⁴

The physical symptoms identified included sleeplessness, failed appetite, breasts becoming flaccid and the cessation of lactation. In extreme cases, “moral insanity” may have ensued, especially among women whose moral character was in question at any point prior to pregnancy:

In cases in which there has been - even long previously - a tendency to intemperate habits, these may reappear, in the earlier stage, in the form of aggravated dipsomania, in which the morbid craving for stimulants may assert itself in the most intense form; and the patient will, if unable to procure ordinary stimulants, greedily consume eau-de-Cologne, spirits of sal volatile, valerian, or spirits of lavender, should such be left within her reach.⁹⁵

The tone and language is comparable to that used in reference to a child. The focal idea was that the patient was ill because she seemed unaware of the expectations and constraints placed upon her as a woman and as a mother. In her study of women and madness, Elaine Showalter has argued that women were deemed sick when they violated

⁹⁴ Leishman, *A System of Midwifery*, 666.

⁹⁵ Leishman, *A System of Midwifery*, 667. “Sal volatile” is a mixture of ammonium bicarbonate and ammonium carbonate used as a smelling salt. “Valerian” is a drug made from the flowers of the valerian plant.

the domestic role.⁹⁶ In his description of a puerperal mania case, Leishman's language illustrates well Showalter's conclusions:

In mania there is almost always, at the very commencement, a troubled, agitated, and hurried manner, a restless eye, an unnaturally anxious, suspicious, and unpleasing expression of face; sometimes it is pallid, at others more flush than usual; - an unaccustomed irritability of temper, and impatience of control or contradiction; a vacillation of purpose, or loss of memory; sometimes a rapid succession of contradictory orders are issued, or a paroxysm of excessive anger is excited about the merest trifle. Occasionally, one of the first indications will be a sullen obstinacy, or listlessness and stubborn silence.⁹⁷

The interpretation of these symptoms were based primarily on the physician's understanding of appropriate female behaviour. While the diagnosis of mental disorder is by necessity based on interpretational analysis, the identification of symptoms nonetheless is a telling indicator of societal expectations and demands upon women.

The treatment accorded puerperal insanity sufferers was equally fraught with socio-cultural elements. Patients were to be kept under constant supervision, administered nervous sedatives, such as opium, if necessary, and be secluded and restrained during recuperation.⁹⁸ Leishman's prescribed treatment for puerperal insanity was very similar to the one used to treat neurasthenic patients. Neurasthenia (a form of hysteria) was a nineteenth century diagnosis used to define the illness of women who

⁹⁶ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*. New York: Penguin Books, 1985, 133. See also Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*. Toronto: Oxford University Press, 2000.

⁹⁷ Leishman, *A System of Midwifery*, 663.

⁹⁸ Leishman, *A System of Midwifery*, 670-71.

exhibited any manner of symptoms, most of which did not conform to the dictates of lady-like conduct.⁹⁹ The integral component of treatment was to separate the patient from the harmful stimulation of family and friends, keep her confined to bed rest and ensure that she was isolated from all connections except with that of her doctor.¹⁰⁰ In the cure, the doctor-patient relationship was taken to its patriarchal extreme. The patient's sole connection with society was through her physician, whose professional ideals and socio-cultural mores set the agenda. His notion of 'well' was imposed upon the sufferer. Her health was determined by her ability to conform to his expectations. As with neurasthenic patients, puerperal insanity sufferers represented a danger to themselves and their family. Treatment for neurasthenia was a means of isolating patients from their families, and themselves, by ensuring that the only contact was with the physician who would be able to recognize the proper physical and mental condition of the patient.

By the 1920s, causal agents had been isolated as contributing to the onset of puerperal insanity.¹⁰¹ In *Lippincott's Quick Reference Book*, Rehberger advanced infection, anaemia, hemorrhage or prolonged lactation, physical and mental exhaustion, worry and strong emotions, heredity, toxæmia and chorea as all potential contributors. The author, however, failed to explain how these factors led to insanity.¹⁰² Once again,

⁹⁹ Showalter, *The Female Malady*, 134-35.

¹⁰⁰ Showalter, *The Female Malady*, 139.

¹⁰¹ *Lippincott's* refers to "puerperal insanity" as the "insanity of gestation".

¹⁰² Rehberger, *Lippincott's Quick Reference Book*, "Insanity of Gestation," no page numbers.

actual treatment differed little from that accorded a puerperal insanity case fifty-five years prior to the publication of *Lippincott's*:

Endeavor to ascertain and correct the cause. Cases due to nervous instability, worry, exhaustion should be benefited by rest, change of environment, wholesome food, fresh air, hydrotherapy, and perhaps iron, arsenic, or calcium. The patient should be kept under careful supervision to prevent her doing harm to herself or others. She should not nurse her child.¹⁰³

The only real difference was in the prescribed drugs available for extreme cases (i.e. morphine). Even then, Rehberger encouraged the use of hot packs rather than drugs for maniacal and insomniac patients.¹⁰⁴ By the 1920s, however, the concept of the 'rest cure' had fallen out of favour among physicians. The physicians no longer needed to impose his authority. By the 1920s, it was likely that his professional stature would have been recognized by the patient and her care-givers. Further, his ability to dispense medication, and knowledge of its effects, would have bolstered his standing among patients. *Lippincott's* was more apt to prescribe medication than an extended course of any specific rest treatment.

The post-partum period also represented a threat to the physical health of mothers. In fact, one of the greatest fears for any woman giving birth in the late nineteenth and early twentieth centuries was the contraction of a sepsis infection leading

¹⁰³ Rehberger, *Lippincott's Quick Reference Book*, "Insanity of Gestation," no page numbers.

¹⁰⁴ Rehberger, *Lippincott's Quick Reference Book*, "Insanity of Gestation," no page numbers.

to puerperal, or childbed, fever.¹⁰⁵ The fever could often be fatal, and was a chronic problem in many births, both within and outside hospital walls. American historian Judith Walzer Leavitt has shown that childbed fever was the largest contributor to maternal mortality statistics.¹⁰⁶ “Amongst the causes of death in childbirth,” concluded Irvine Loudon in his comprehensive statistical analysis of maternal mortality, “puerperal fever had no rival.”¹⁰⁷ The onset of puerperal fever began following labour and was indicated by feelings of depression, headache, pain in the abdominal region with swelling, weakening pulse, vomiting and/or diarrhea and the skin was often hot and dry. If the case worsened, the patient could become delirious, the pulse could quicken and the pain could increase significantly.

Leishman offered a detailed description of the sufferings of the final stages of puerperal fever:

She now lies on her back, breathing rapidly, sometimes with her knees drawn up, and exhibiting on her countenance that appearance of ghastly distress which is so painful to witness. The surface and extremities become cold; the mechanical impediments to perfect respiration give something of lividity to the countenance; and the symptoms, becoming otherwise more grave, indicate that the period has been reached when hope may be well-nigh abandoned. At this point, the abdominal pain, tenderness, and tension often diminish; and, but for the ominous pulse and countenance, we might fancy that the patient was better. The diarrhoea continues, the stools being passed in bed; vomiting occurs, without any

¹⁰⁵ Suzann Buckley, “The Search for the Decline of Maternal Mortality: The Place of Hospital Records,” *Essays in Canadian Medicine*, Wendy Mitchinson and Janice Dickson McGinnie, eds. Toronto: McClelland and Stewart, 1988, 153

¹⁰⁶ Leavitt, *Brought to Bed*, 154

¹⁰⁷ Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950*. Oxford: Clarendon Press, 1992, 49.

retching, of a dark or greenish matter; and the patient may now breathe with greater ease. The pulse is undiminished in frequency, but it is otherwise changed for the worse, as is indicated by the thready or imperceptible character. The intellect generally remains clear to the end; but in some cases low muttering delirium, subsultus tendinum, and other similar symptoms, come on before death ensues.¹⁰⁸

Patient fears, understandable given the illness as *Lippincott's* describes it, were reinforced by the general lack of knowledge surrounding the containment and treatment of childbed sickness. While aware of the contagious nature of the disease, physicians could only really suggest preventative cleanliness. In regards to the etiology, Leishman concluded that there was not a specific infection which attacked puerperal women, but rather that the peculiar condition of a pregnant woman made her especially susceptible to pre-existing infections, such as scarlet fever, variola and other diseases of that class. Further, the puerperal condition was believed to alter the effects of the disease, thus modifying its course, and the physician's ability to recognize the particular type of infection.¹⁰⁹

Leishman did, however, distinguish between peritonitis (abdominal), metritis (uterine) and vaginitis (vaginal), distinguished by the actual site of infection.

Once a woman contracted the fever, physicians were unable to do anything other than alleviate some of the suffering and let the infection run its course. In some instances, physicians attempted heroic measures, such as bloodletting or purgatives, but modern medicine has shown that the only true combatant could have been antibiotics for such a

¹⁰⁸ Leishman, *A System of Midwifery*, 706-707.

¹⁰⁹ Leishman, *A System of Midwifery*, 694.

bacterial infection.¹¹⁰ It is in the diagnosis of puerperal septicaemia that medical advances demonstrated a distinctive difference over a fifty year period. However, treatment remained frighteningly similar despite increased knowledge about the origins and causes of infection.¹¹¹ The establishment of the field of bacteriology made significant advances in the study of bacterial infections in the early twentieth century.¹¹² By the 1920s, several bacilli had been isolated as the causal agents in post-partum infectious fevers.¹¹³ However, as yet, no specific combatants had been developed to eradicate the noxious bacteria. Physicians, therefore, focused on prophylaxis through cleanliness.

Once contracted, according to Rehberger, about 95% of cases would end in recovery after several weeks or months. Nonetheless, puerperal infection remained one of the more significant reasons for maternal mortality in Canada. Treatment included a thorough cleansing of the perceived infected area and, if necessary, a cleansing of the uterine walls to remove debris. Otherwise,

[a]bsolute rest, fresh air, Fowler's semi-sitting position, hot applications to the lower abdomen, an initial calomel and saline purge, frequent bathing

¹¹⁰ Leishman, *A System of Midwifery*, 714-715.

¹¹¹ Antibiotics, the most successful means of combatting bacterial infections, would not be introduced into obstetrical practice until the 1940s.

¹¹² See John Farley, "Parasites and the Germ Theory of Disease," in *Framing Disease: Studies in Cultural History*, Charles E. Rosenberg and Janet Golden, eds. New Brunswick, N.J.: Rutgers University Press, 1992, 33-49. For Canada, see Lesley Biggs, "The Response to Maternal Mortality in Ontario, 1920-1940," M.A. Thesis, University of Toronto, 1982.

¹¹³ These were saphrophytes of putrefaction, streptococci, staphylococci, the bacillus coli, gonococcus, and pneumococcus. See Rehberger, *Lippincott's Quick Reference Book*, "Puerperal Infection," no page number.

with warm water, or alcohol and water, equal parts, the withdrawal of child from the breast, plenty of water to drink, and a nutritious soft and liquid diet are essential.¹¹⁴

The treatment was designed first and foremost to address the individual symptoms rather than a means of eliminating infection. For extreme cases, physicians might have attempted drainage of abscess cavities or a variety of serums, but the primary causal agent of childbed fever was simply beyond the reach of 1920s medical knowledge.

As evidenced by the minimal evolution of tone and information between Leishman's *A System of Midwifery* and Rehberger's *Lippincott's Quick Reference Book*, instruction in midwifery had progressed very little in half a century, and many freshly graduated doctors were still starting practices with minimal experience in confinement cases. "Although he may have attended the statutory number of labours required by his college or university," noted W. Japp Sinclair in 1897, "he has enjoyed few advantages of direct practical instruction and example."¹¹⁵ The danger increased substantially for a parturient woman when an inexperienced accoucheur made use of instruments or anaesthesia:

The young practitioner sees a woman suffering under the pangs of labour; he can relieve these by anaesthetics; normal labour is a process which requires time; the practitioner does not like waiting, and he has appliances by which he can abridge the process of normal labour . . . he may be unable to diagnose the presentation, so he must trust force alone; he has seen little or nothing of the puerperal state, so he is hardly in a position to

¹¹⁴ Rehberger, *Lippincott's Quick Reference Book*, "Puerperal Infection," no page number.

¹¹⁵ W. Japp Sinclair, "The Section of Obstetrics and Gynaecology," *Montreal Medical Journal* 26, 4 (Oct., 1897): p. 292.

appreciate the risk to his patient and to recognise some of even the immediate effects of operative midwifery.¹¹⁶

Poorly trained practitioners would often bring about severe injury and death. The maternal mortality rates of the nineteenth century remained high, despite the growing involvement of physicians.

The teaching of obstetrics in the Manitoba Medical School curriculum, however, had changed in the same 50 year period, even if the texts that students used had changed very little. As previously noted, as early as 1884, the School offered a course in obstetrics. In 1894, however, the faculty of the Manitoba Medical College consisted of Dean J. Wilford Good, who lectured in Ophthalmology and Otology, J.R. Jones and R.M. Simpson were the department of Medicine, J. Blanchard was professor of Anatomy, J.O. Todd taught Anatomy and Surgery, Gordon Bell lectured in Bacteriology and Pathology, H.H. Chown provided lectures in Surgery, and A. Diamond was the Professor in Professor of Obstetrics and Diseases of Women and Children.¹¹⁷ Most professors lectured in more than one specialty area. It was indicative of the breadth of knowledge in the obstetrics field when its only professor was able to master specializations in obstetrics, gynecology and pediatrics.

The experience that obstetrical training physicians received was haphazard and dependent more on the individual doctor's priorities than on the fulfilment of necessary

¹¹⁶ Sinclair, "The Section of Obstetrics and Gynaecology," 292-93

¹¹⁷ Cited in Manitoba Medical College, *Annual Announcement of the Eleventh Year Session*, 1894-95.

educational exigencies. One Manitoba physician, Murrough O'Brien, remembered his first maternity case in 1888, and his resentment of the midwife:

This particular midwife knew me at once for a green medical student and her shrewd eyes probably detected the nervousness I was trying to cover up. "Dearie," she said slyly, "how many babies have you delivered?" . . . It was an easy birth, thank God, but my part in the delivery was damn' small. The midwife joined me at the bedside and at the crucial moment she nudged me out of the way with her hip and took command. The only thing she allowed me to do was cut the cord. When it was all over and I was preparing to leave, the old scoundrel offered me a mug of ale but I turned my back on her and marched out. She had the last word though. As I went up the stairs to the street I heard her cackle, "You didn't do too badly, sonny. At least you didn't faint."¹¹⁸

Even as O'Brien confessed his lack of skill and knowledge, he undermined the midwife's style and deportment. Still, he admitted that he learned from her.

In order to graduate in 1885, students were required to have at least six months experience in a lying-in hospital and have attended six births. However, if the six births attended were anything like the above, a physician may have in fact received precious little by way of training.

By the mid-1920s, students were exposed to maternity cases more often, and the field of obstetrics and gynaecology was a recognized chair in Canadian medical schools. The first female chair of the Department of Obstetrics and Gynaecology, Elinor F. E.

¹¹⁸ Cited in Robert Tyre, *Saddlebag Surgeon: The Story of Murrough O'Brien, M.D.* Toronto: J.M. Dent & Sons, 1954, 35.

Black, fondly recalled her experiences with "fourth year maternity calls" as a student in 1929:

Squeezing into the cab in dead of night, waking up on the way, scrambling into a gown and mask and taking her place on the two-step platform "at the business end of the table." Lowly students were excluded from going to the West 4 kitchen for the "fourth stage of labour"; that was where the obstetrician, residents and interns went after the case was concluded. Everyone made toast and drank coffee, and interns got a chance to ask questions that might have shown them up in front of students.¹¹⁹

Nonetheless, starting physicians often lacked practical experience.

The case of Samuel Peikoff's first case at the Royal Alexandra betrays the "greenness" of a young intern. Determined to catch a maternity case, despite the head nurse's reluctance to call interns except at the last possible moment, Peikoff rushed down at the first hint of an emergency medical call. He was present to crown the birth, but the baby was not breathing, so he made heroic, though futile, efforts to save the infant. Appealing to the knowledge of the nurse, "old Ginger", the doctor was stunned to learn that the foetus was a stillbirth: "It's been dead for over two weeks. The mother is syphilitic and has a four Wassermann. What do they teach interns nowadays?"¹²⁰ In response, Peikoff blurted out an obscenity at the nurse and quickly left the case room.

The situation was typical of the hierarchical structure evident in hospitals. Physicians were the authority on the wards, responsible for nurses, orderlies, matrons and any other staff. Nurses were often reprimanded for disobeying or questioning that

¹¹⁹ Julie Vandervoort, *Tell the Driver: A Biography of Elinor F. E. Black, M.D.* Winnipeg: University of Manitoba Press, 1992, 43.

¹²⁰ Peikoff, *Yesterday's Doctor*, 5.

authority.¹²¹ However, as historian Charles Rosenberg has demonstrated, lines of authority were not always as clearly defined in reality as they were in rhetoric. In the first two decades of the twentieth century, hospital administrations underwent fundamental changes in order to accommodate the growth of hospitals and the technologies of modern medicine. The simple superintendent of the institution was superseded by a Board of Directors, a Medical Superintendent, a Nursing Superintendent and management for everything from the physical plant to the kitchen.¹²² Peikoff recognized the need for a negotiation of power and thus went to see the head nurse to beg her forgiveness:

I antagonized Ginger, who had more knowledge of obstetrics through years of experience than most of the staff doctors. She would be an ideal teacher. Without her help my career was worthless. I could never go out to a country practice without knowing how to do a confinement. I could not allow a vendetta to take root between myself and Ginger. My future was at stake.¹²³

In this case, the physician recognized the importance of obstetrical training to his particular practice and turned to a perceived authority. It can only be left to the imagination as to what kind of training a physician who was less interested in obstetrical cases may have received as a student.

Not all physicians were as open to negotiation as Peikoff's account, and the rigid adherence to hospital hierarchy could have tragic consequences. In the final semester of

¹²¹ See Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1970*. Toronto: Oxford University Press, 1996.

¹²² Rosenberg, *The Care of Strangers*, 273-282.

¹²³ Peikoff, *Yesterday's Doctor*, 6.

the obstetrics rotation, Peikoff was approached by "Ginger" to assist in a difficult caesarian. The doctor in charge, identified as Dr. Morley, had a reputation as a difficult colleague, overly confident in his surgical abilities. During a troubled delivery that had lasted over forty hours, the head nurse suggested that an obstetrician be consulted. Morley responded by threatening to have the nurse fired and decided to proceed with a caesarian section. Unable to find another physician to assist, Ginger asked Peikoff. The recollections of the young doctor's experience deserve to be quoted at length:

Dr. Morley began his Caesarian with a long incision, plunged his clumsy hand into the abdomen, at the same time explaining his findings, "Some loops of bowel are plastered by adhesions which I am separating with my hand." Somewhere along the clumsy operation he had torn a large artery. Pools of blood welled up into the wound. He packed it with large gauze packs, hoping the blood would clot from pressure. He stood there applying pressure for several minutes. He finally pulled out the gauze, and blood again welled up. He flew into a rage in his attempt to find the injured artery.

Meanwhile, the anaesthetist warned him that the patient's blood pressure was dropping and her pulse was getting shallower. The place began to resemble a slaughter house - bloody sponges everywhere, pools of blood on the table and on the floor.

He cursed the nurse, threw the "useless forceps" on the floor, and in his fear and anger began to take it out on me for my poor clumsy assistance. I naively suggested he pack the wound again and put in a call for a surgeon. This really triggered off a spasm of vitriolic insults. Instead of calling an experienced assistant, he continued his butchery while the mother was deteriorating relentlessly. The ordeal was punishing. I was becoming faint. The end came abruptly.¹²⁴

In this case, the hospital hierarchy was intact, unfortunately for the patient.

¹²⁴ Peikoff, *Yesterday's Doctor*, 7-8.

Following their years of training in schools and in hospital, many freshly-graduated physicians hung out their shingle in rural communities in order to gain experience and build a practice. While an internship period in a hospital eventually became obligatory, at the turn of the century, the diploma in hand meant full qualification. Shortly after graduating from the Manitoba Medical School in 1897, Murrough O'Brien made the decision to set up practice in Dominion City, a small farming community in southern Manitoba. He boarded the train with nothing other than a small black case with some medical equipment.¹²⁵ Renting a shack behind the local laundry, O'Brien "opened for business with little more than a hypodermic syringe, obstetrical forceps, dental forceps, dressing scissors, and a thermometer."¹²⁶

In the last years of the nineteenth century, physicians were making preliminary inroads into the birthing chamber, and for the most part were present only in complicated cases or at the request of wealthy patients. Jacalyn Duffin's study of the late nineteenth century physician, James Langstaff, demonstrates that medical attendance during childbirth in the later half of the century.¹²⁷ In the forty years that he practised, Langstaff incorporated a myriad of new techniques into his practice. His approach to childbirth, however, remained relatively unchanged.¹²⁸ The advent of forceps and the introduction

¹²⁵ Tyre, *Saddlebag Surgeon*, 81.

¹²⁶ Tyre, *Saddlebag Surgeon*, 85.

¹²⁷ Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life*. Toronto: University of Toronto Press, 1993.

¹²⁸ Duffin, *Langstaff*, 178-217.

of anaesthesia in childbirth cases offered physicians a technological advantage over midwives who had been the traditional birth attendants.¹²⁹ Once acquired, instruments and anaesthetic were indeed used by physicians. Even in his relatively early practice, Langstaff frequently made use of forceps and chloroform.¹³⁰ However, the country doctor did not always have access to the technological advantages of modern medicine. The primary obstacles in a case could be a blizzard, impassable roads or simply a 50 mile ride on horse back to get to the patient. Isolation meant that rural practitioners had to adapt to the available resources be it for instruments, transportation, assistance or communication.

Both rural and urban physicians, nonetheless, recognized the strong financial appeal of obstetrical cases, even if they acknowledged the predominance of nature:

[The doctor] received a hurried summons to his first local maternity case, and he took off on his bicycle, pedalling furiously along Main Street with a pack of snarling mongrels and three or four excited young boys in hot pursuit. Nature might very well produce the offspring unassisted, but Murrough felt that his claim to the fifteen dollar fee would be less subject to dispute if he were present for the event.¹³¹

In this instance, the doctor arrived in time, but he did not collect a fee for his services.

However, subsequent cases would well make up for the loss on the first one. By the spring of 1954, Murrough O'Brien had been present at the delivery of over 9000 babies.¹³²

¹²⁹ For a discussion of forceps and anaesthesia in childbirth see Judith Walzer Leavitt, "'Science' Enters the Birthing Room: Obstetrics in America since the Eighteenth Century," *Journal of American History*, 70, 2 (Sept., 1983), 281-304.

¹³⁰ Jacalyn, *Langstaff*, 192-195, 201.

¹³¹ Tyre, *Saddlebag Surgeon*, 93-94.

¹³² Tyre, *Saddlebag Surgeon*, 4.

One of the biggest obstacles faced by rural practitioners was the vastness of the territory they covered and the resulting large patient load. Paul Starr's assertion that the better transportation and the advent of the telephone improved accessibility is not as applicable to conditions in rural Canada.¹³³ As Charlotte Borst has shown, "poor roads and the isolation of rural life limited the kind of help a country doctor doing obstetrics could summon in an emergency."¹³⁴ One December night in 1898, O'Brien was forced to contend with three confinement cases: "In the period from dusk to dawn, they made the run around a fifteen mile isosceles triangle five times, stopping briefly at the three points of the triangle each time for the doctor to inspect progress, encourage one mother to speed things up, and tell the other two to take it easy."¹³⁵ C. Lamont MacMillan of Cape Breton confronted a similar situation as late as the spring of 1935. After the first birth, he instructed the other two women to take two ounces of castor oil, after which he took a nap at the home of his nurse. In such instances, the physician would often rely on the hospitality of neighbours, travelling to the home of his patient's neighbour by horse and sleigh, to ensure that he was near a telephone.¹³⁶

The isolation factor greatly influenced the treatment received by parturient women. Difficult cases encountered by rural practitioners would often have to be

¹³³ See also Starr, *The Social Transformation*, 66.

¹³⁴ Borst, *Catching Babies*, 123.

¹³⁵ Tyre, *Saddlebag Surgeon*, 132.

¹³⁶ C. Lamont MacMillan, *Memoirs of a Canadian Doctor*. Markham: PaperJacks, Ltd., 1977, p. 30-31. I have used MacMillan's memoirs because they support trends I have identified, despite its different setting.

addressed immediately in the home of the patient. Urban doctors, however, would have the luxury of hospital services and consultations. O'Brien encountered his first Caesarian section in 1897, in the home of a patient who had been in labour for several hours. Conditions were not favourable and O'Brien was working in the pioneering days of the operation:

This was to be bedroom surgery and he draped the area around the woman's bed with sheets soaked in a solution of carbolic acid. Two planks laid across a pair of sawhorses brought in from the yard were used to hold dressings, instruments, and a basin of water to rinse his hands. A chair in position near the patient's head held the can of chloroform and the gauze mask. Chloroform was harder on a patient's heart, but a safer bet for lamplight surgery than inflammable ether.

Murrough started the woman under anaesthesia and then passed the container to the white-faced husband who had been instructed how to drip more chloroform to the mask over his wife's face when the doctor called for it. . . The operation took an hour. It was completed at thirty minutes past midnight on Christmas morning and the gift to the father was a healthy, seven-pound baby boy. But the birth of the child took the life of the mother. Shock and haemorrhage drained her of her last remaining strength and the doctor sat beside the bed, helpless to do aught but watch the life flicker out.¹³⁷

While it is not clear whether being in hospital would have led to a different outcome, the tone certainly underscores the hardship of make-shift surroundings.

By the 1940s, the common practice in difficult deliveries was to evacuate the mother to the nearest hospital. However, conditions were not always favourable. One such case confronted the Maritimer MacMillan in December of 1941. His patient had been seven months pregnant when she began to haemorrhage severely; by the time the doctor arrived, she "was just about bled out". MacMillan recalled:

¹³⁷ Tyre, *Saddlebag Surgeon*, 110.

I was in a predicament then. There was no God's way in the world to get her to hospital. You certainly couldn't take a woman in that condition over Smoky by horse and sleigh, and then fifty or sixty miles more by car to a hospital. I learned that the coastal vessel, ASPY, might be in Ingonish in two or three days, but at the time there was ice and no assurance that the vessel would be able to get there in three days on her regular trip. And I couldn't stay and look after her while waiting for the boat. I had more than five thousand people in my own end of the county to look after.¹³⁸

His only option was to induce labour and hope for the best. The baby was stillborn, but the mother survived the ordeal. Again, it is impossible to tell whether hospitalization would have changed the outcome, but it is clear that rural physicians supported evacuation in difficult cases. In so doing, they supported the reputation of the hospital as the safest environment.

Another incident occurred in the summer when the weather would have been favourable but the distance to hospital was too great. After rushing a haemorrhaging patient into his car, MacMillan headed for the closest hospital, which happened to be in North Sydney:

It was summertime, and I knew I could get her to the hospital within an hour. I had only gone a mile, or a mile and a half, when I looked back and there was blood running on the floor of the car and out the door. I figured then she wouldn't make it to North Sydney, so I turned in at the first gate, which happened to be Malcolm MacDonald's. I knew his daughter, Dolly, was home on vacation and she was a trained nurse. . . . Immediately, we cleared the kitchen, put the patient on the kitchen table. By this time she had some dilation of the neck of the womb and I gave her a little picotin. We delivered the baby in fairly short order, but the baby had not survived.¹³⁹

¹³⁸ MacMillan, *Memoirs of a Canadian Doctor*, 120.

¹³⁹ MacMillan, *Memoirs of a Canadian Doctor*, 131-132. Picotin was a drug used to induce labour.

Despite his preference for a hospital, circumstances would often prevent travel or accessibility, and thus the experiences of women in rural communities were often as influenced by the weather as by the physician's preference. By 1942, more than half of recorded Canadian births occurred in hospital. However, it is clear from these accounts of a physician practising in the 1940s, that in some ways, the childbirth experience remained very much the same in the first half of the twentieth century.

The distance covered by rural practitioners and the absence of means of communication or transportation sometimes meant that women were alone at the time of confinement, despite arrangements to the contrary. One such case occurred when MacMillan was forced to wait for the confinement of a patient. As the family had no telephone, the doctor made his way to a neighbour's home a quarter of a mile away. Despite two visits to the patient over the course of the day, when she finally went into labour, MacMillan missed the entire episode.¹⁴⁰

The absence of a birth attendant was not uncommon, especially for rural women, whose childbirth experiences wound up being an immediate family affair by circumstance. "These women were cut off from the usual support persons who surrounded women through pregnancy," writes historian Nanci Langford in her study of birth on the Canadian prairies. "They had no regular access to the care and knowledge of mothers, sisters and aunts, or even friends and neighbours."¹⁴¹

¹⁴⁰ MacMillan, *Memoirs of a Canadian Doctor*, 56-57.

¹⁴¹ Nanci Langford, "Childbirth on the Canadian Prairies, 1880-1930," *Journal of Historical Sociology*, 8, 3 (Sept., 1995): 279-280.

The medical profession, for its part, decried the absence of medical practitioners in rural communities. In her study of maternal mortality, Helen MacMurphy attributed fifteen percent of maternal deaths to the absence of medical attendance or post-partum care. “The lack of medical care in outposts is a serious matter... There can be no doubt that better provision for medical, hospital, nursing service and emergency domestic services would save the lives of many of our mothers.”¹⁴²

In response to alarms over high maternal mortality rates, the Government of Canada launched the Maternal and Child Hygiene Division (hereinafter MCHD) through the Department of Health. As a federally supported public health bureau, the positions of the MCHD represented those views of the medical profession. These views, however, were distributed for public consumption. The publications of the organization and the career of its director, Helen McMurchy, speak volumes about the expectations of the medical profession with respect to childbirth attendance.

The Division fell under the direction of MacMurphy, a prominent physician and social reformer. The first tactic was an education campaign aimed at encouraging women to seek physician attendance. A series known as the "Little Blue Books" were developed to teach hygiene and public health standards, including childbirth care. The primary message advocated physician attendance at all births. However, the leadership of the new branch realized the financial and geographical improbability of all women seeking out medical help during confinement. They therefore produced a series of letters - *The*

¹⁴² Helen MacMurphy, “Maternal Mortality in Canada,” *CMAJ*, 17 (Dec. 1927): 1436.

Prenatal Letters - offering prenatal advice at the request of expectant mothers, as well as a more comprehensive publication, entitled the *Canadian Mother's Book*, whose purpose was to help women prepare for childbirth.

While the *Canadian Mother's Book* and the *Prenatal Letters* were widespread, there is little evidence to determine whether the advice was followed by readers. However, given that the creation of the publication was a response to several chronic social concerns - including high infant and maternal mortality - and the fact that the contents of the advice fairly represented the concerns voiced by the medical community, it is fair to assume that they represented prevailing professional attitudes towards motherhood and childbirth.

Appointed head of the Child Welfare Division of the newly organized federal health department in 1920, Helen MacMurchy's career was fairly consistent with the expectations of a middle-class professional woman at the turn of the century.¹⁴³ Born in 1862, MacMurchy's career path followed that of many of her pioneering generation making early forays into the public world of employment. She spent her early working years as a teacher in Toronto's Collegiate Institute, of which her father was principal. However, her ambitions brought her back to school; in 1899, at the age of 39 she graduated from the Ontario Medical College for Women. By 1901, she had obtained her M.D. degree from the University of Toronto achieving the distinction of being the first

¹⁴³ Kathleen McConnachie, "Methodology in the Study of Women in History: A Case Study of Helen MacMurchy, M.D.," *Ontario History* LXXV, 1 (March, 1983), 64-65.

woman appointed to the resident staff at the Toronto General Hospital.¹⁴⁴ After completing post-graduate work under Sir William Osler at Johns Hopkins University, MacMurchy set up practice in Toronto, specializing in the care of children and in obstetrics and gynaecology.¹⁴⁵ As a female physician, MacMurchy was a pioneer in a mostly male bastion; however, her choice of specialties was representative of the only medical realm truly open to women. Her authority as a doctor came not only from her professional training, but also was rooted in her role as a woman caring for children and parturient women. Her private medical practice was short lived, and in 1906, she accepted an appointment as inspector of the feebleminded for the Province of Ontario, marking the beginning of her public service career. In 1911, she was appointed Ontario's special investigator into infant mortality. The reputation forged in her capacity as inspector ultimately led to her selection as head of the federal Child Welfare Division.

In her position at the Child Welfare Division, MacMurchy played a prominent role in social policy debates as a physician, while maintaining a maternalistic reputation. She "used her position as civil servant, lecturer and writer to stress the fundamental importance of the maternal and domestic role."¹⁴⁶ Consequently, despite her status as an unmarried professional woman, MacMurchy was able to direct the rhetoric emanating from the department of health in relation to maternal and infant care. Her attitudes were

¹⁴⁴ McConnachie, "Methodology in the Study of Women in History," 63.

¹⁴⁵ Biographical information drawn from Sir Charles G.D. Roberts and Arthur Leonard Tunnell, eds. *The Canadian Who's Who*, vol II. London: The Times Publishing Co., 1936.

¹⁴⁶ McConnachie, "Methodology in the Study of Women in History," 64.

clearly reflected in the projects of the Child Welfare Division. Through the Welfare Division publications and investigations, domestic chores were being defined in scientific terms, and thus motherhood itself was perceived as a science. MacMurchy's work in particular blended the annals of scientific medicine with the realities of the domestic experience.

Dianne Dodd has argued that MacMurchy used her position to "preserve, and to have recognized, aspects of women's traditional nurturing role in childbirth," thereby demonstrating that "some professional women had a broader view of maternal health care."¹⁴⁷ Undoubtedly, MacMurchy's recognition, for example, of the limits of available medical service in rural communities demonstrated a willingness to accommodate policy to the needs of patients. However, this apparent flexibility may have been more representative of professionals at large than any gender sensitivity exhibited by MacMurchy. Both the Canadian Medical Association and the Canadian Nurses' Association were cognisant of the needs of under-serviced rural areas, and accepted the necessity of some form of health care provision for maternity cases in the absence of physicians. Both these organizations at times advocated the services of midwives in the absence of trained medical help.

Some of the primary obstetrical related publications emanating from the Child Welfare Division in the 1920s were the *Prenatal Letters*. Nine letters in total - one a

¹⁴⁷ Dianne Dodd, "Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneering Women," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. Ottawa: University of Ottawa Press, 1994, 137.

month - were mailed to Canadian women eager for professional childbearing advice. The *Prenatal Letters* programme was inaugurated in April of 1926 and in its first year of service, the programme distributed four thousand four hundred and eight sets of letters - 3140 in English and 1268 in French.¹⁴⁸ In addition to direct requests, the Division compiled the names of prospective mothers through doctors, hospitals and visiting nursing programmes. Further, by 1931, the Canadian Medical Association was making use of the *Letters* through their Health Services. The publication grew to such an extent that by 1931 approximately 58,000 sets of letters had been distributed with a slated printing of 50,000 each of both the French and English letters.¹⁴⁹

Correspondence from prospective mothers or their family members often specifically requested the *Prenatal Letters*, indicating that they were well-received among the public.

In 1931, Emile Dauphin of Brockville, Ontario, wrote:

I was in correspondence few months ago with you relating that many of our mother were dieing because they have not had medical care. We have raised a family of 12 children and I feel like if my wife is not feeling in the

¹⁴⁸ "Child Hygiene Section Report", Nov. 1, 1929 - March 31, 1931," Division of Maternal and Child Health, National Archives of Canada (hereafter N.A.C.), Department of Health Records, RG 29, Volume 992, File 499-3-7 pt. 5. In 1931, there were just under 250,000 total live births in all of Canada. See F.H. Leacy, M.C. Urquhart and K.A.H. Buckley, eds., Historical Statistics of Canada, first edition. Ottawa: Statistics Canada, 1983, B1-14.

¹⁴⁹ "Child Hygiene Section Report", Nov. 1, 1929 - March 31, 1931," Division of Maternal and Child Health, N.A.C., Department of Health Records, RG 29, Volume 992, File 499-3-7 pt. 5.

normal way and I suppose that these monthly letters of advise covering the entire period of prenatal and postnatal will help us.¹⁵⁰

It is interesting to note that Mr. Dauphin was informed enough to request the specific *Letters*. His source of information, as outlined in his letter, was the Sudbury Star, and he noted that there was no available physician in his municipality. It is impossible to determine whether this writer was representative of typical communications with the Division of Child and Maternal Welfare, however, it is more than likely that many of the requests came from rural inhabitants or the working-classes who for either reasons of finances or location did not have access to physician services or advice.

Given the amount of fear and confusion which surrounded a pregnancy, the *Prenatal Letters* likely represented a very valuable source of information. However, there were limits to what the letter could provide and the social overtones undoubtedly biassed the amount and type of conveyed information. The first letter greeting mothers from the Division of Child Welfare stressed two fundamental ideas. These were the duties of motherhood and the necessity of physician attendance. Women were reminded of their duty: "She owes it to herself, to her family and to her country to take such care of herself during pregnancy that she will have a safe and easy confinement and a healthy happy baby."¹⁵¹ Science and medicine were the prescribed components of that safe and easy confinement: "It is our desire and hope that you will take advantage of the

¹⁵⁰ Letter to Dr. Helen MacMurchy, Division of Maternal and Child Health, N.A.C., Department of Health Records, RG 29, Volume 992, File 499-3-7 pt. 5.

¹⁵¹ Letter 1, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

opportunity we are able to offer you, and thus have the experience of medical science to be of benefit to you and the new life which is now in your keeping."¹⁵²

The first piece of advice imparted by the *Letters*, therefore, acknowledged the physician-centred advice with which mothers would be inundated and stayed true to the professional belief in medicine: "Our first and most important instruction to you as the expectant mother is that you will at once place yourself under the care of your family physician for regular advice and supervision."¹⁵³ Women were warned against accepting the advice of friends or family that differed from that of the physician. This advice, while authoritative, recognized the environment in which an expectant mother may find herself during pregnancy. The doctor and medical science, nonetheless, were always the final authority: "You want a healthy, happy baby and you will have one if you do as we have told you."¹⁵⁴

As with any situation where women sought advice in pregnancy and childbirth, all aspects of the mother's life were open to suggestions. Lifestyle, eating habits, bathroom patterns, even emotional state were subject to scrutiny. A pregnant woman was no longer an individual, but a patient dealing with a condition for which medical treatment was the only real solution: "When a woman becomes pregnant, she is starting on a period of

¹⁵² Letter 1, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁵³ Letter 1, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁵⁴ Letter 6, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

considerable strain, a period when skilled advice is required."¹⁵⁵ Symptoms of pregnancy were listed, including those that may have suggested complications with the pregnancy. The *Letters* warned against home remedies and once again stressed the skill of the physician.

Subjects normally considered offensive in polite conversation were openly addressed in the *Letters*. Mothers were told to keep track of the amount of urine passed and seek medical attention should it be less than three pints.¹⁵⁶ In preparation for breast feeding, women were instructed on how to wash their nipples and perform nightly rituals that would prevent cracking and tenderness once the baby was born.¹⁵⁷ The question of class bias should be considered in evaluating the tone of the *Letters*. While a specific audience was never identified, it is possible that the authors were quite aware that their publications would not wind up in the homes of more delicate upper and middle-class women who might be offended by the blunt content. Rather, the information was for the consumption of farm women and working women whose lifestyles would negate the possibility of medical attendance, and whose sensibilities might therefore be less delicate.

Perhaps, the most interesting advice contained in the *Letters* did not deal with the logistics of preparation or the requirement of physician attendance. Almost from the

¹⁵⁵ Letter 2, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁵⁶ Letter 6, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁵⁷ Letter 7, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

beginning, expectant mothers were reminded their emotional state played a large role in the healthy development of the child. Despite the fears of childbirth, the financial demands of medical attendance and the costs associated with a new born, women were reminded to be happy.

Keep yourself cheerful at all times. Do not read any disagreeable papers. Seek pleasant friends, read bright cheerful books, and plan as many days as you can to be with people you like and in surroundings that please you.¹⁵⁸

The very tone of this advice betrays a class bias inconsistent with the perceived audience receiving these letters. Certainly working-class mothers could not afford the time to read yet alone the luxury of finding pleasant surroundings. The writers expected mothers to be able to devote everything to their pregnancies - a situation simply impossible for many women whose socio-economic position demanded full time family or external work. Still, like Leishman, the Letters focussed on a psychosomatic condition over which patients not physicians were the apparent guardians.

Diet and health care prescriptions were based on assumptions about socio-economic background. Women were told to eat vegetables, fresh fruits, and plenty of milk. Fresh air and rest were encouraged, while "overwork, violent exercise, lifting heavy objects, running the sewing machine for long periods" were potential causes of miscarriage.¹⁵⁹ Eight hours of sleep a night was perceived as necessary, and a nap after

¹⁵⁸ Letter 2, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁵⁹ Letter 3, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

the noon meal was encouraged, preferably in a room to oneself.¹⁶⁰ Undoubtedly, only middle-class women had the luxury of following such directions.

Advice in preparing for the baby's arrival was also somewhat class-centred. Extending over two pages, the inventory of necessities for the baby alone might well have been staggering to a poor mother. Among other things, women were instructed to have on hand two dozen diapers, four night-dresses, outdoor clothing, several blankets and a myriad of toiletries for baby, such as a bath thermometer, comb and absorbent cotton.¹⁶¹ However, that was not all. A second single page list noted all the articles needed for home confinement, including three night-gowns, a bed pan, and several items for the doctor's use.¹⁶² While the lists were complete and very thorough, they offered little alternative ideas for women who simply could not afford to indulge scientific medicine.

To whom were the *Letters* then addressed, working-class mothers unable to seek professional attendance or a broader audience of women? There seems to be little accommodation for poor women whose mothering tasks would include finding the money to afford a new addition to the family. The *Letters* outlined an ideal situation and expected mothers to subscribe to such a model.

¹⁶⁰ Letter 4, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁶¹ Letter 5, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁶² Letter 6, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

Nonetheless, the advice did offer women a means of preparing for their births, whether or not a physician was available. In the final letters, mothers were given simple instructions which chiefly sought to prevent infection during confinement. Directions on sterilization were provided, and cleanliness was stressed repeatedly. For the actual confinement, the importance of sterile surroundings was underscored:

Select a bright room, accessible to the bath-room, and remove all unnecessary articles and hangings, then have it thoroughly cleaned.

Have plenty of hot water ready.

Braid your hair in two braids, take a warm sponge bath, put on a clean night gown and white stockings and kimono. Prepare the bed by covering the entire mattress with several thicknesses of newspapers, or a fresh oilcloth, or rubber sheeting. The bottom sheet is put on over this.¹⁶³

Presumably, sterile preparation would have limited the chances of infection even among poorer women who would have been unable to obtain the prescribed amenities.

In response to these very situations, the Maternal and Child Welfare Division distributed the *Canadian Mother's Book*. First published in 1923, the *Canadian Mother's Book* maintained the patriotic character of 1920s maternal advice literature:

The Government of Canada, knowing that the nation is made of homes, and that the homes are made by the Father and Mother, recognizes you as one of the Makers of Canada. No National Service is greater or better than the work of the Mother in her own home. The Mother is "The First Servant of the State."¹⁶⁴

¹⁶³ Letter 8, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁶⁴ Division of Maternal and Infant Welfare, *The Canadian Mother's Book*. Ottawa: Department of Health, 1927, 1.

Borrowing the image of "Republican motherhood" from the American revolutionary period, Canadian public health and social reform officials associated motherhood with national duty.

The *Mother's Book* provided some basic preparatory instructions, but it was the *Supplemental* that offered direct birthing advice. Once labour began, the physician was the central figure in prescribed advice literature. While the *Prenatal Letters* briefly described the sensation of contractions, the primary directive was to notify the doctor and nurse.¹⁶⁵ No information was forthcoming on how to safely manage a birth. Not even the definitive authority on maternal care, the *Canadian Mother's Book*, provided complete instructions on labour. For the most part, women were told to seek medical care and trust the physician.

Nonetheless, maternal health experts did not entirely turn a blind eye to the condition of women unable to seek out appropriate medical attention. The case of rural women was especially poignant given the geographic obstacles of distance and weather that often prevented the timely arrival of any medical assistance. Consequently, the *Canadian Mother's Book* had an accompanying supplement intended for distribution by medical experts only and only for use in out-post homes.¹⁶⁶ Dianne Dodd has argued that the Supplement illustrated "the contradiction between the public health message, which

¹⁶⁵ Letter 8, Child and Maternal Health Division, Department of Pensions and Health, RG 29, volume 993, file 499-3-7, pt. 10.

¹⁶⁶ Helen MacMurchy, *Supplemental to the Canadian Mother's Book*. Ottawa: Department of Health, 1923, cover.

stressed preventive medicine through regular physician consultations, and the reality of restricted medical services."¹⁶⁷

Without publicly acknowledging the role of a community of women traditional of births in rural communities, the Supplement offered instruction on "the neighbour's part" in unassisted home deliveries: "If, when the time is drawing near, your husband has to be away all day, he will arrange some plan with a neighbour so that you will have someone with you."¹⁶⁸ The publication went on to describe in detail the stages of birth and the responsibilities placed on the untrained birth attendant.

As in the *Prenatal Letters*, the first emphasis was cleanliness and the need for sterile conditions:

BE Clean. Take off your dress. Scrub your hands and arms clean with soap and hot water. Put on a clean washdress and apron. Roll up the sleeves over your elbows, scrub your hands and arms again and clean your nails. Scald, scrub and clean THOROUGHLY all the pitchers, basins and dishes you need. Put on plenty of water to boil.¹⁶⁹

After specific preparations, the "neighbour woman" was instructed on how to perform a pelvic examination and introduced to the three stages of labour:

Sometimes the Doctor "makes an examination", that is, he feels with his fingers inside the maternal passage to find out if everything is all right. But you must not do this, and you must never let anybody else do it but the Doctor. It may cause the death of the mother if you or any unskilled person tried to make such an examination.¹⁷⁰

¹⁶⁷ Dodd, "Helen MacMurchy," 137.

¹⁶⁸ MacMurchy, *Supplemental*, 139.

¹⁶⁹ MacMurchy, *Supplemental*, 143.

¹⁷⁰ MacMurchy, *Supplemental*, 146.

Comparable in thoroughness to a medical text, the *Supplement* offered estimated length of each stage and vivid descriptions of the course of labour. The tone of the language was simple, and often reassuring: "Do not hurry. Do not use force. BE quiet. Be gentle. Be kind. Be very patient. Nature needs time to bring about the birth."¹⁷¹ The place of non-medical birth attendants was openly recognised, even if only in passing: "You have been sent for to help a mother in the time of her greatest need, because you are the nearest and best person available. It is a great honour to you. You will be able to help her."¹⁷² Despite the dire warnings contained in the *Prenatal Letters*, the Supplement assured the bedside attendant that such a presence was acceptable, even necessary.

Departmental publications maintained the disclaimer that medical attention was preferable. Still, as Dianne Dodd concludes, they "did give recognition to a women's public health concern, and conveyed far more information about the process of labour and childbirth than was typical of popular medical books at the time."¹⁷³ In part, this was a result of concerns about high maternal mortality rates, but also there was a recognition of the financial and geographical limits placed on many Canadian women.

The high cost of physician attendance, especially to poor farmers, was an important issue to many rural families.¹⁷⁴ Often, this meant that family members would

¹⁷¹ MacMurchy, *Supplemental*, 157.

¹⁷² MacMurchy, *Supplemental*, 143.

¹⁷³ Dodd, "Helen MacMurchy," 143.

¹⁷⁴ See Langford, "Childbirth on the Canadian Prairies," 278.

be the sole assistance for birthing women, especially among recent immigrants who were unfamiliar with the culture, and often maintained traditional practices. O'Brien encountered one such case in his first year of practice. The woman had been in bed for five days, with the husband periodically attempting to dislodge the baby between farm chores. The scene was described as:

a typical immigrant's home on the prairies - a one-room shack with dirt floors and a sod roof. What the doctor saw when he entered was one bed that held his patient. The bed stood high on pine blocks and under it were a number of boxes filled with children. Two hens sat on eggs in a box at the foot of the bed. Two geese doing the same thing occupied a barrel at the head of the bed. Six young pigs were penned in one corner. Two calves were tethered in another corner.¹⁷⁵

The patient was in a septic coma, as the child had been a still-birth and had remained lodged for over five days. O'Brien remained in the home for twenty-two hours, fully expecting the mother to die. However, when he saw the husband the next day, he was told that the patient was out of bed, and doing much better.

Despite the eagerness of many physicians, in many cases, a midwife would be the primary attendant. Peikoff learned early in his practice that the services of the physician were seen as a last resort. After being called to a complicated maternity case, the doctor was shocked to learn that the midwife had used fresh cow-manure to lubricate the birth canal.¹⁷⁶ He found the patient in bed, with the husband and midwife present, along with

¹⁷⁵ Tyre, *Saddlebag Surgeon*, 101.

¹⁷⁶ Peikoff, *Yesterday's Doctor*, 31.

several chickens and a couple of pigs. To the best of his ability, the young doctor set about recreating hospital procedure in a soddy on the prairies:

A number of sterilized newspapers were placed over the bloody mattress. With the help of Henry [the driver] and the midwife, Mary [the mother] was placed crosswise on the sagging bed, with her buttocks hanging over the edge. A special heavy maternity belt, equipped with stirrups, was fashioned around her back legs. It was then tightened to maintain the separation of her flexed thighs throughout labor. This home-made maternity leather belt replaces the two nurses in city hospitals, whose sole job it is to keep the thighs apart. I placed an inflated rubber ring under her buttocks. This served as a trough to direct the washings into a tub.¹⁷⁷

In spite of all his attempts, Peikoff found that the circumstances were simply too foreign to allow adequate re-creation of hospital procedure. After seventy-two hours of labour, the baby's head was still high in the birth canal. Peikoff repeatedly attempted to apply the forceps, but to no avail. In the end, he wound up using his hands to remove the still-born infant. After the incident, Peikoff lamented the entire event: "My gloves were torn, my sterile drapes disappeared, I had put my hand up into her uterus so many times. In an orthodox case, one hesitates to go up even once. She'll probably die of childbed fever. I thought of Semmelweiss. What would he think of me?"¹⁷⁸

Unforeseeable complications could also create unimaginable problems for rural physicians. The rudimentary conditions and lack of appropriate facilities for medically-prescribed birth management would often lead a rigid physician into greater trouble if he failed to be adaptable:

¹⁷⁷ Peikoff, *Yesterday's Doctor*, 31.

¹⁷⁸ Peikoff, *Yesterday's Doctor*, 36.

Mrs. MacKenzie [midwife] . . . held the kerosene lamp while I got the instruments on. The lamp was a large one that held more than a pint of kerosene. Just as I applied the instruments, Mrs. MacKenzie dropped the lamp! The odd thing was, the shade didn't break, but the lamp itself broke and the kerosene spilled. Instantly, there was a fire from the floor right up to the ceiling of the room. . . [T]he lamp had fallen on a large mat. I dropped what I was doing and within a few seconds rolled up the mat, blaze and all. Somebody opened the window for me and we threw the mat out the window without being burned. Then while the room was still dark, except for some light from the blaze outside, I delivered the baby.¹⁷⁹

At times, the doctor's techniques could be the very cause of the problem. When MacMillan approached a routine case, he would use chloroform as an anaesthesia. On one such case, a pint of chloroform was dropped on the floor: "The patient went to sleep immediately, and so did the nurse, but she managed to stay on her feet somehow. For some reason the chloroform didn't bother me at all. Miss Lyttle [the nurse] then started to cough. She was standing there, sound asleep and coughing."¹⁸⁰

Nonetheless, rural physicians were able to adapt their procedures to the environment, and many chose to maintain the techniques taught in hospital. O'Brien's methods remained the same in over fifty years of rural practice: "The doctor puts his mothers completely under anaesthesia. This way, he says, they are fully relaxed, labour is shortened, there are fewer tears, and the mother has a much easier time of it. Murrrough's technique requires the use of obstetrical forceps."¹⁸¹

¹⁷⁹ MacMillan, *Memoirs of a Country Doctor*, 126.

¹⁸⁰ MacMillan, *Memoirs of a Country Doctor*, 61.

¹⁸¹ Tyre, *Saddlebag Surgeon*, 249.

The presence of a midwife or other female attendant was fairly common, and often physicians would rely on them. Remarks throughout James Langstaff's daybook hint at the importance of women attendants in the late nineteenth century, demonstrating that their presence was in fact expected by physicians.¹⁸² What is particularly telling is that women attendants remained a constant well into the twentieth century. When MacMillan encountered a pregnant woman with pneumonia during his first winter in practice, he went out in search of the local midwife, Mrs. MacKenzie, for assistance.¹⁸³ Many times, women eschewed the doctor in favour of the local midwife. Peikoff learned in his first year of practice of the traditional adherence to midwives among his patients. A phone call from a local farmer requesting that the doctor stand-by the phone prompted the young physician to inquire further. Peikoff learned that the family had a "middle wife from Old Country" and that if the baby had not arrived in two days, they would contact him.¹⁸⁴ Physicians were quick, however, to warn of the dangers of relying on midwives without the presence of a physician. MacMillan wrote of two cases where he was turned away, and noted that in both cases death ensued.¹⁸⁵

In 1910, O'Brien moved from Dominion City to Winnipeg in order to start a new practice. His first experiences in private practice were less than promising: "There were about a dozen other tonsil-snatchers in the same building and the tricks used to corral

¹⁸² Duffin, *Langstaff*, 185.

¹⁸³ MacMillan, *Memoirs of a Country Doctor*, 126-127.

¹⁸⁴ Peikoff, *Yesterday's Doctor*, 27.

¹⁸⁵ MacMillan, *Memoirs of a Country Doctor*, 171-72.

patients were diverse and devious. In a less dignified business it would be termed cut-throat competition."¹⁸⁶ However, the city practice did have its advantages. O'Brien relished the "first-class hospital facilities available for surgical and maternity cases."¹⁸⁷ To a physician, the sterile surroundings of the hospital were the ideal conditions, and even a country doctor cherished the benefits. By the 1920s, a hospital birth was conducted with precision and rigorous attention to procedure:

When in labour the patient is admitted to the Waiting Room of the Maternity Ward; she is put to bed and given a full sponge, after which the pubic hair is completely shaved. . . Following this, the patient is given two soap suds enemata, about one hour elapsing between the treatments providing the labour is not progressing too quickly . . .

When the woman is ready for delivery , she is moved by stretcher on to the obstetrical table in the Case Room, and an intern is in attendance to administer a few drops of chloroform and ether (1:2) anaesthetic with each pain, and to encourage the patient to make good use of the uterine contractions. She is then draped with a sterile gown, stockings, and sheet, and the vulva is thoroughly washed with a 55 lysol solution.

Following delivery and washing-up, tight abdominal and breast binders are applied, and the patient is removed to a warmed bed in the Ward. A drachm of an ergot preparation is given by mouth, and an ice-cap is applied to the lower abdomen. The ergot preparation is repeated in half-drachm doses thrice daily until six doses have been given.¹⁸⁸

The entire procedure was predictable and very much under the control of the physician in charge. If Elinor Black's testimony is accurate, a normal hospital birth had become a routine medical procedure.

¹⁸⁶ Tyre, *Saddlebag Surgeon*, 196.

¹⁸⁷ Tyre, *Saddlebag Surgeon*, 194.

¹⁸⁸ Elinor Black as cited in Vandervoort, *Tell the Driver*, 112-113.

While many cases were treated in hospital, for the first few decades of the twentieth century, a higher proportion of births occurred in the homes of patients. The scientific techniques taught in hospital, therefore, were adapted to suit a variety of birth chambers, especially in urban practices which boasted proximity to hospital and other physicians. Home births were a standard part of urban practices. As one obstetrician noted in 1923:

It is always essential for us to remember that in 90% of all cases, the labour is spontaneous, and that a vast proportion of these mothers must always be delivered in their own homes. These women cannot come to us in our hospitals and training-schools, but, on the other hand, we of these schools must go to them. We must send to them the well-trained doctor and the nurse, and provide in the home a well-adapted and efficient technique.¹⁸⁹

Medical professionals advanced their place in the birthing room, and the necessity of attending women in their homes. Through espousal and practice of scientific techniques, physicians were able to access the previously closed domain of the birth chamber.

However, the process of medicalization was gradual.

An urban practice could present as many peculiar cases as those seen in rural practices. As a medical student, Murrough O'Brien, living in a rather dilapidated building, was approached by one of his neighbours to treat a stomach condition. The woman, it turned out, was a prostitute and her illness was deemed an "occupational hazard". O'Brien's response was to track down the "visitors" and determine which one would make a suitable husband. Once a candidate had been chosen, the doctor set an

¹⁸⁹ W.W. Chipman, "Problems of Obstetrical Practice," *The Canadian Medical Association Journal* 13, 6 (June, 1923), 380.

elaborate trap and the gentleman in question married the patient.¹⁹⁰ Straying somewhat beyond the dictates of his training and oath, O'Brien applied his own moral and social bias in providing what he perceived to be the proper care for a mother and child.

* * *

With a tenuous hold on professional authority and medical skills, the role of physicians in the birthing chamber was ill-defined and often adaptable to the surroundings. While the educational treatise espoused an ideal for birth attendance, the reality of conditions prevented many practitioners from following prescribed techniques. Further, the lack of educational standards for obstetrics often meant that experience garnered far more than degrees, and physicians looked to whoever could address the situation. Unfortunately for some, however, not all were able to circumvent professional hierarchy.

Childbearing, in the first few decades of the twentieth century, remained, in the words of one contemporary social critic, a "threshold on which nature and culture confront[ed] on another."¹⁹¹ While physicians were armed with technical knowledge emanating from the culture of science, childbearing was still perceived by medical professional, and the lay public, as a natural process which created a strong barrier to medicalization. Ultimately, it was only by bringing scientific procedures, or rudimentary

¹⁹⁰ Tyre, *Saddlebag Surgeon*, 69-74.

¹⁹¹ Julia Kristeva, "The Maternal Body," in *m/f*, no. 5-6 (1981), 159.

replicas of the same, that physicians gained a foothold as childbirth attendants.

Chapter Five

The Border Between Science and Motherhood: Nurses and Maternity Care in *Canadian Nurse* in the Early Twentieth Century

For the first half of the twentieth century, the majority of births in Canada occurred outside the hospital setting. Typically, women had their babies either in their family homes or in small maternity homes. Moving into the twentieth century, physicians were increasingly present at the actual moment of confinement. But most care during the hours before and after childbirth was provided by local midwives, district or visiting nurses, family or friends of the mother. Consequently, the nursing role in home childbirth cases was different from that of institutional care-givers.

The previous chapters have demonstrated that physicians focussed on the symptoms of pregnancy and the mechanics of the childbirth process. This chapter will show that the role of nurses in the birth room extended to broader care. Nursing professionals incorporated both the social and physical well-being of parturient women, especially in the case of home births. "[The nurse's] approach was far superior to that of the physician," writes historian Karen Buhler-Wilkinson, "because she was trained to see the body as a whole, while the physician's vision was distorted by a preoccupation with special pathological conditions."¹ This chapter further argues that nurses, because of the demands of professionalization and the gendered expectations, acted as a liaison between medicine and the traditional communities of women associated with childbirth. The presence of nurses, straddling the worlds of science and womanhood, contributed to the medicalization of childbirth. As women care-givers, nurses easily were admitted into the

¹ Karen Buhler-Wilkinson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930*. New York: Garland Publishing, Inc., 1989, 89-90.

homes of parturient patients. The presence of a female attendant was *on par* with common expectations of the childbirth experience. The duties of the nurse were more closely associated with the notion of traditional (aka midwifery) care-giving. Nurses would, among a variety of other duties, cook and clean, care for other children, as well as dispense medical advice. They were, therefore, more directly involved in the routine lives of patients than their medical brethren.

Despite this apparent domestic role, nurses were also seeking to establish themselves as legitimate medical professionals. They brought with them the gospel of public health and sanitary reform espoused by physicians and the health reform movement. They also brought with them the rigid authoritative structure of medical hierarchy. Modern nursing, taught through the medical schools and often with direct instruction from physicians, “made its entry into Canada at the invitation of a physician. Nursing education was, from the moment of its inception, incorporated into the domain of physicians and hospitals.”² The situation in Winnipeg was no different. The nursing school was located in proximity to the Manitoba Medical School, and instruction was offered by resident physicians of the Winnipeg General Hospital. Thus, nurses acted as a mediator between the traditional world of childbirth and the modern one of scientific medicine. In so doing, they helped build the necessary bridge which brought doctors to the bedside of parturient patients.

² Laretta A. Hazzard, "Towards Professionalization: Ontario Nursing, 1874-1925." MA Thesis, University of Western Ontario, 1991, 9-10. As cited in R.D. Gidney and W.P.J. Millar, *Professional Gentlemen: The Professions in Nineteenth-Century Ontario*. Toronto: University of Toronto Press, 1994, 326.

In order to examine the attitudes of the nursing profession towards maternal and obstetrical care, articles addressing these topics have been drawn from Canada's national nursing magazine, *Canadian Nurse* (hereinafter *CN*). Beginning in 1905, the content of these articles reflected the opinions of the nursing elite and leadership.³ Published articles can not speak to the opinions of all nurses in early twentieth century Canada. However, they do provide some insight into the direction of nursing professionalization and its relationship to childbirth attendance and maternal care.⁴ The journal literature outlined the *expected* role of the obstetric nurse.

The nursing approach to parturient care was shaped by related, yet distinctive, influences on the profession. These primary influences were gender and professionalization. Gender segregation was inherent in the very character of nursing. It was highlighted by early attempts at professionalization, which were bound by the dictates of gender codes and social mores that pitted the science of medicine against the decorum of femininity. As historian Katheryn McPherson has argued: "Women's virtual monopoly over nursing work was justified in terms of 'natural' female nurturing, and trained nurses' presence at the bedside was legitimized by their adherence to Victorian

³ 1905 was the year of inception for *Canadian Nurse*.

⁴ Julia Kinnear, "The Professionalization of Canadian Nursing, 1924-1932: Views in the *CN* and the *CMAJ*," *Canadian Bulletin of Medical History*, 11, 1 (1994): 155. However, historian Veronica Strong-Boag has maintained that "Canadian rank-and-file nurses appear somewhat less alienated from nursing's elite than do their American counterparts," in "Making a Difference: The History of Canada's Nurses," *Canadian Bulletin of the History of Medicine* (hereafter *CBHM*), 8 (1991): 231.

codes of femininity.”⁵ In order to achieve a niche in the realm of social services and medical care, nursing relied on the feminine association with “caring and curing” which offered women a place in the public sphere by encouraging their roles as natural care-givers.⁶ As professional care-givers, nurses could mother away social problems and illness.

The work of Florence Nightingale was a primary contribution to the modern interpretation of nursing. Incorporated into medical folklore as a result of her work during the Crimean War, Nightingale wrote voluminously on the state of nursing and medicine in the mid-nineteenth century. One of her best known works, *Notes on Nursing: What It Is and What It is Not* (1860), defined the future of the profession by intertwining education and training with the art of nursing.⁷ Nightingale believed that nursing was an occupation suitable for middle-class women because it was “an art to be acquired by practice and discipline - a training of moral fibre - not a mere gathering of technical expertise.”⁸ Ironically, Nightingale dismissed the germ theory prevalent in the medical community on the grounds that the “new scientific training ... would turn nurses into “medical women” and deflect them from their proper task of being sanitary

⁵ Kathryn McPherson, *Beside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: Oxford University Press, 1996, 39.

⁶ Diane Dodd and Deborah Gorham, eds., *Caring and Curing: Historical Perspectives on Women and Healing in Canada*. Ottawa: University of Ottawa Press, 1994, title page.

⁷ Nancy Boyd, *Three Victorian Women Who Changed Their World*. New York: Oxford University Press, 1982, 194.

⁸ Monica E. Baly, *Florence Nightingale and the Nursing Legacy*. London: Croom Helm, 1996, 52.

missioners.”⁹ It was Nightingale’s association of nursing with missionary-type work that elevated the character of nursing as an occupation for women, and carved out an important role for women in health care delivery.

The gendered character of nursing had a particular significance in parturient care, where the relationship with patients was often built on a perception of common experiences and interests. The nurse’s place at the bedside was intrinsically related to her faculties as a woman. In an address given to the nursing graduating class of 1915 at the Calgary General Hospital, R.B. Deane noted of the qualities of a successful nurse: “I would place first a sympathy of heart and hand such as woman alone can best display - nothing sloppy or maudlin, if you please, but a fine womanly feeling of tender consideration.”¹⁰

Much of nursing attendance was associated with providing care and nurturing for the family, a typical feminine role. Gertrude Breslin, of the Woman’s Hospital and Infants’ Home in Detroit, wrote of nursing duty: “The ability of the mother to nurse the baby depends so much upon her night’s rest, that the duty of the nurse is, to relieve her of the care of the infant as much as possible.”¹¹ In such instances, the nurse acted as surrogate care-giver for the family. Emphasis was also often placed on the role of the nurse as provider, rather than deliverer of medical care. “As a district nurse,” wrote a

⁹ Baly, *Florence Nightingale*, 23.

¹⁰ R.D. Deane, "Address," *CN* XI, 8 (Aug., 1915), 431-32

¹¹ Gertrude Breslin, "Obstetrical Nursing," *Canadian Nurse* (hereafter *CN*), III, 4 (April, 1907), 195

Toronto nurse, “my chief work is to visit families as systematically as possible, to proffer food for their mouths, clothes for their bodies and a willing ear to their complaints.”¹² Feeding, clothing and caring for the patient and family were the standard duties of nurses; tasks not far removed from those of the mothers they were tending. This link with femininity was central to the position that nurses adopted in the medical community because “nursing relied on an image of feminine respectability to legitimate nurses’ presence in the health-care system and their knowledge of the body.”¹³

The language used by writers in the nursing journal reflected the feminine character of nursing. Technical or clinical articles in *Canadian Nurse* were fewer in number than those in medical journals. The tone adopted by nursing authors was usually more vernacular. In an article detailing the relationship between the private duty nurse and families, Isabel M. Stewart, of the Winnipeg General Hospital, likened the home care of the patient to that of a musician in a chaotic orchestra:

The private nurse is like a wandering musician, called to play her part in many a stormy chorus, and many a lame and lagging refrain. She encounters a great variety of instruments, in all degrees of disrepair, from the simple lute with the little rift silencing its music, to the noble Stradivarius, all unstrung and hopelessly warped, its sweet music jingling, its harmony all discord.¹⁴

¹² G.T. Barrow, "District Nursing," *CN*, IV, 8 (Aug., 1908), 369.

¹³ McPherson, *Bedside Matters*, 17.

¹⁴ Isabel M. Stewart, "The Private Nurse in her Relation to the Family," *CN*, IV, 4 (April, 1908), 155.

The language is playful, and even poetic, striking a very different note from the strictly professional tone of medical journals. The tone, meant to be palatable to feminine readers, was reminiscent of the articles in women's magazines.

The accepted principles of scientific medicine were nonetheless advocated by both professions. Nurses, trained through an apprenticeship system in hospitals, easily adapted scientific theories of asepsis into their daily routines.¹⁵ As historian Kathryn McPherson has shown, the strict institutional hierarchy and discipline characteristic of nursing education, ensured that student nurses did not question the dictates of their medical superiors.¹⁶ Thus, the advocacy of asepsis and cleanliness were incorporated into nursing routines with little resistance from nursing leadership. Unlike the *Canadian Medical Association Journal* (hereinafter *CMAJ*) which often featured articles debating medical theories, *CN* offered merely instruction. In maternity cases, nurses were given instructions on aseptic preparation for delivery, without question to the merits of any of the procedures.¹⁷ At the Burnside Maternity Hospital in Toronto, for example, nurses were responsible for prepping patients during the first stage of labour:

First of all, a simple enema of two pints is given. The vulva and pubis are then clipped carefully, after which a full tub bath is given, the hair washed, and the body examined for eruptions of any nature. Then follows a vaginal douche of lysol dr. I, green soap dr. I and a water of one quart. The body from the waist line to the knees, and lastly the external genitals are thoroughly cleansed with green soap and water and lysol one half per cent. After this the vulva is carefully protected with a (1-3000) bichloride

¹⁵ McPherson, *Bedside Matters*, 85.

¹⁶ McPherson, *Bedside Matters*, 32.

¹⁷ For an example of some of the medical debates in the *CMAJ*, see chapter II (4).

pad, the patient is put to bed and made ready for immediate examination by the house doctor.¹⁸

In this instance, the instructions if not the actual language and tone were just as technical as medical journals. No debate was presented on whether the patient should be in bed or sitting. In fact, like the medical journals, the patient was obscured by the specifics of the condition and the scientific approach to treatment. Nurses, therefore, demonstrated a shared understanding with physicians.

District and home nurses, however, often differed in their interpretation of health care delivery. Their care-giving role demanded that they be familiar with family and community needs. The conditions that met them in a home setting did not provide for the sterile preparation of hospital procedure. They, nonetheless, adapted medical procedure to suit the conditions of the family, while relaying advice and instruction on matters related to health and hygiene. Writing in *Canadian Nurse*, Isabel Stewart argued:

Her first care is to see that, even at some sacrifice to the family, the patient is provided with the requisites of illness - clean and comfortable bedding, good food, and such medicines and appliances as are necessary. She husbands her resources with jealous care. . . Barrel-hoops and newspapers, excelsior and rags, are converted into sick-room accessories. She maketh men her ministers, and lures tributes from corner-bakeries and back-lot gardens for her patients' modest tray. She is introduced to furnaces and floor-mop, and has even been known to attach a wash-tub, without seriously imperiling her professional reputation.¹⁹

In many ways, the task of the nurse was comparable to that of a physician in home care situations. As noted in previous chapters, physicians attending home births

¹⁸ W.M. Brerton, "Obstetrical Nursing," *CN*, VIII, 3 (March, 1912), 119.

¹⁹ Isabel M. Stewart, "The Private Nurse in Her Relation to the Family," 156.

accommodated their treatment procedures to suit the conditions and equipment available. However, the scope of nursing care extended beyond immediate treatment. Finding food and mopping floors were part of the nurse's professional duty. The doctor prescribed scientific-based treatment, such as ample nourishment or aseptic conditions. Part of the nurse's role was ensuring that wherever possible, patients were given the opportunity to carry-out medical instructions. "The chief virtue of a nurse... lay in her ability to understand and follow the directions of the physician and to know the limits of independent judgement."²⁰ The nurse acted as a bridge between the medical world and the family or community she served.

The association of nursing with more domestically-oriented tasks created a dual identity for nurses. In hospital settings, nurses were involved in direct bedside care. Through district nursing organizations, school services and welfare program, however, nurses were placed in the role of educators and community liaisons working directly in the neighbourhoods and with families. In this capacity, nurses were tasked with an instructive role. Nurses' educative capacity was increasingly emphasized as public health nursing and visiting nursing services began offering regular employment opportunities for graduate nurses.²¹ Previous to the advent of public nursing, patient contact with nurses would have been limited to the very rich, who could afford hospital care or a private duty nurse, or the very poor, who were brought to hospital in a desperate state. These cases would have been more directly supervised by physicians and the nurse's role limited to

²⁰ Gidney and Millar, *Professional Gentlemen*, 326.

²¹ Buhler-Wilkinson, *False Dawn*, 112.

that of assistant. With public nursing, however, the nurse represented the first line of contact between the patient and the medical world. Her responsibility, therefore, as a representative of scientific training, extended to preventative care, which required providing instruction on health and hygiene.²² “As a district nurse” wrote G.T. Barrow in *Canadian Nurse*, “I know myself to be part of a large organization, which is working steadily, consistently and systematically to one definite end. I know that I continue to be an essential factor in the lives of those with whom I have to do. The home life of upwards of one hundred and fifty families is familiar to me.”²³ Nurses were key links to the community, and their influence contributed to a broader societal acceptance of medicine.

This influence was particularly felt in maternity cases, where nurses represented a bridge from the traditional circle of women attendants during childbirth to the medicalization of parturition. In obstetrical cases, the social service role made nurses responsible for educating mothers about pre-natal care. In such instances, their function as bedside attendants at childbirth cases was overshadowed in favour of public health work. Nurses echoed medical beliefs in the “incalculable importance of scientific supervision of the life of the pregnant mother and due provision for her care at delivery;” but they also saw a role for themselves “during the weeks of worry and trial following labor.”²⁴

²² Buhler-Wilkinson, *False Dawn*, 89.

²³ Barrow, "District Nursing," 369.

²⁴ Harris, "Pre-Natal Education in the Home," 339.

Instructions delivered to mothers by nurses were similar to those of their medical counterparts, infiltrating all aspects of a mother's life:

When the nurse makes her first visit she takes a social survey of the patient in her surroundings, gives instruction as to personal hygiene, in diet, bathing, clothing, fresh air, sleep, exercise, how to conserve her strength for the good of the baby and for the strain of labor and nursing. . . The mental and physical condition of the mother is noted, a test of the urine is made, and the co-operation of the whole family solicited. The nurse should impress on the mother the necessity and importance of maternal nursing. In her social survey the nurse should ascertain if the patient had the means for procuring proper food in sufficient quantities and is free from anxiety. If not, she studies out what is best to be done, and put in motion the proper machinery for securing relief needed.²⁵

The nurse's responsibility, by this account, extended beyond instruction into procurement of the perceived necessities. While she shared the same treatment opinion of physicians, her involvement in the case often picked up where the physician's role ended. Nurses ensured that the medical prescription for childbirth was met and that the patient heeded all instructions .

The training received by nurses in the early twentieth century shaped the care they provided patients by underscoring the hierarchical structure of medicine and limiting the role of nurses at the bedside. Nursing training in Canada reinforced the strict domestic nature of nursing work. In order to achieve a desired level of professionalism, nursing leadership had to negotiate with medical leaders who consequently influenced the scope of nursing work. As historian Julia Kinnear has shown, the attempt by nursing leadership to promote greater training requirements in the 1920s was met with opposition from

²⁵ "Prenatal Care," *CN*, VI, 8 (Aug., 1915), 454-55.

physicians who claimed that increased scientific training went beyond the necessities of nursing training.²⁶

The animosity of physicians was a constant concern for nursing leadership, who often defended their profession against medical criticisms. As late as 1927, Toronto nurse Ethel Cryderman felt compelled to address the concerns of medical professionals in her article on pre-natal nursing:

The wrong interpretation of our work still seems to exist in the minds of many physicians. If they could realize that the public health nurse is no way assumes any of their duties, that she is there to interpret their wishes and can be of valuable assistance to them, they might use her more extensively. The fact that she is able to give a service in teaching the hygiene of pregnancy and infancy during the important period, should appeal to them.²⁷

Physician fears, it seemed, led to the elimination of nurses from the immediate bedside at the time of confinement. The nurse's narrowly medical role was therefore lessened. Bound by the hierarchical structure of their training, they parroted the advice of their perceived physician superiors.

In her 1927 essay, Ethel Cryderman reiterated the subservient role of nurses to physicians. She quoted a public health nursing text that made such subservience clear:

In her relation to the physicians the nurse must be so convinced of the rightness of their procedures that she gives unquestioning loyalty and confidence, since her work is of necessity an interpretation of their ideas and wishes. She must appreciate the fact that every detail of maternity work originates in, and is guided by the medical profession.²⁸

²⁶ Kinnear, "The Professionalization of Canadian Nursing," 165.

²⁷ Ethel Cryderman, "Pre-Natal Work," *CN*, 23 (Oct., 1927), 539.

²⁸ Cryderman, "Pre-Natal Work," 536.

The position of the nurse was unquestionably that of service to the medical profession. Often, this meant advocating the use of physicians despite expectations of home attendance. Oshawa public health nurse, B.E. Harris, noted: "Our strongest efforts are directed to induce her to go to the hospital for her laying-in with her first baby, or, if that is impossible, to secure care in the home, or to have a professional nurse if possible."²⁹ Nursing leadership accepted the authority of the medical profession and adopted medical rhetoric in their own professional publication.

The *CN's* attitudes towards the problems of high maternal mortality and the presence of midwifery in Canada, for example, were carbon copies of the arguments espoused in the *Canadian Medical Association Journal*. In the case of maternal mortality, the discourse of nationalism and duty were a common refrain, especially in the aftermath of the war. H.W. Hill, in a 1923 *CMAJ* article underscored the nationalist argument in relation to maternal duty: "From the point of view of the race both stillbirths and miscarriages are of great importance, indicating as they do potential citizenship lost to the population."³⁰ Writing about public health nursing in Manitoba, Elizabeth Russell employed similar arguments in relation to the need for adequate maternal and infant care:

The war has brought home the fact as never before that a nation's strength lies in her people. . . Public health work is distinctly patriotic. It aims to conserve life at its earliest foundations, to prevent disease, to care for the physical welfare of the individual and community, and, as Public Health Nurses, it is our great privilege to have a share in securing for every child

²⁹ Harris, "Pre-Natal Education in the Home," 341.

³⁰ H.W. Hill, "Prenatal Negligence and Loss of Population," *CMAJ* 11 (Sept., 1921), 615.

that degree of physical (and, therefore, mental and moral) fitness that will enable them to conscientiously fulfil all the obligations of good citizenship.³¹

The issue of nationality remained important in nursing rhetoric after the war, as evidenced by Margaret Duffield's closing remarks in her 1925 article:

When we consider the principle source of increase in the population is at stake, and that we are always reading in the newspapers of the urgent necessity for immigrants to people our province, would it not be as well for us to strain every effort to have future citizens born right in the country from healthy and vigorous parents.³²

The significance of this rhetoric is twofold. First, it speaks to the nursing profession's acceptance of medical arguments. Second, it gives strong indication that the nursing and medical elite shared similar values and socio-economic backgrounds. The linkage of health care with nationalist sentiment was a product of middle-class faith in the gospel of public health and fears over race suicide.³³ It was supported with eugenical goals if not with pseudo-science.

³¹ Elizabeth Russell, "Public Health Nursing in Manitoba," *CN*, 14, 9 (Sept., 1918), 1289.

³² Margaret Duffield, "Maternal Care in Ontario," *CN*, 21 (July, 1925), 360.

³³ For fears of "race suicide" see Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*. Montreal: McGill-Queen's University Press, 1993, 56-57. For a discussion of middle-class involvement in public health and social reform, see Regina Markell Morantz, "Making Women Modern: Middle Class Women in Health Reform in 19th-Century America," *Women and Health in America: Historical Readings*, Judith Walzer Leavitt, ed. Madison: University of Wisconsin Press, 1984, 346-358; Carol Lee Bacchi, *Liberation Deferred? The Ideas of English Canadian Suffragists, 1877-1918*. Toronto: University of Toronto Press, 1983, 29-33; Marianna Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland and Stewart, 1991, 44-5; Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*. Toronto: McClelland & Stewart, 1990, 13-27.

Even in the area of working professional authority, nurses supported the convictions of the medical profession by their reluctance to advocate the use of midwives in Canada. Concerned over maternal and infant mortality rates well into the 1920s, physicians had attempted to isolate causes for continued high levels despite the success of public health initiatives in reducing other previously unconquerable illnesses such as tuberculosis and typhoid.³⁴ Midwives became easy targets. "Obstetricians and general practitioners alike regarded midwives as ignorant, dirty anachronisms, incapable of appreciating the need for cleanliness or of understanding the basic anatomical and physiological principles of the birth process."³⁵

When the issue of supplying midwives to rural inhabitants was brought up in the early 1920s, *CN* published a carefully worded, though clearly stated, letter to the editor from M.A. Gibson, a registered nurse, that questioned the use of midwives and warned of the potential dangers.³⁶ Despite the obstetrical training accorded nurses in Britain, the Canadian profession was reluctant to embrace the idea of nurses as sole childbirth attendants. Occasionally, *CN* acted as a platform for opponents to the importation of midwives into the Canadian medical system. Demonstrating a much stronger vehemence

³⁴ Nancy Schrom Dye, "Mary Breckinridge, the Frontier Nursing Service, and the Introduction of Nurse-Midwifery in the United States," *Women and Health in America*, Leavitt, ed., 327.

³⁵ Dye, "Mary Breckinridge," 328. For a discussion of the debates over midwifery, see Frances E. Kobrin, "The American Midwife Controversy: A Crisis in Professionalization," *Bulletin of the History of Medicine* 40 (1966), 350-363. The strongest opposition to the elimination of midwives emerged from rural areas where doctors and hospitals were scarce.

³⁶ M.A. Gibson, "Letter to the Editor," *CN*, 19, 4 (April, 1923), 212-214.

than most opponents, Mary Ard MacKenzie wrote a scathing letter to *CN* which was published in 1917: "Some time, when the war is over, and you need to be fed with horrors," wrote Mary Ard MacKenzie, a staunch opponent of midwives, "go out and talk with people who have seen midwives at work, and you will get all you desire."³⁷

As the publishing voice of the nursing profession, however, *Canadian Nurse* overall remained fairly silent on the issue of midwifery. The only real debate on the issue that was published in the nursing journal was the verbatim report published of the meeting of the Nurses' Committee of the National Council of Women, where the midwife question was a central agenda item. The Committee was firmly opposed to midwifery, as evidenced by their invitation to Mary Ard MacKenzie as an expert on the midwifery question. One Committee member, Mrs. R. Bryce Brown, clearly voiced her support for MacKenzie's views:

A graduate nurse will not go into a place and take care of a pregnant woman alone. She will not assume responsibility of child-birth alone. That is what the midwife will do, and she is willing enough to assume the responsibility because she does not know the difference: it is ignorance on her part.³⁸

A review of the articles published between 1905 and 1930 turned up no official pronouncement by the editor or nursing leadership on the ills or benefits of midwifery. Nonetheless, the fact that *CN* allowed itself to serve as a platform for opponents suggests the position of the magazine.

³⁷ Mary Ard MacKenzie, "The Midwife Question," *CN* XIII, 1 (Jan., 1917), 729.

³⁸ "Nurses' Committee of the National Council of Women," *CN*, XIII, 7 (July, 1917), 436.

In her study of Mary Breckinridge's Frontier Nursing Service (FNS), Nancy Schrom Dye concludes that the American nurse felt little sense of sisterhood with the Southern midwives who operated in the Service's region.³⁹ However, the Service practitioners did not approach the midwife tradition with hostility. Part of the program's success, argues Dye, was attributable to Breckinridge's insistence that the midwives be treated cordially and offered any requested assistance. Gradually, women came to trust the nursing service and called upon FSN nurses rather than midwives.⁴⁰ Nurses supplanted the position of midwives by relying on the dissemination of information through the community, rather than aggressive education campaigns that denounced the evils of midwifery. Perhaps, like their colleagues in the medical profession, the perceived 'old world' nature of midwifery did not merit a flurry of professional attention. Both professions simply failed to support the development of midwifery training in Canada and the importation of trained British midwives.⁴¹

The motivating factor behind nursing's attitude was related to the profession's attempt to carve a niche for itself in the medicalized realm. In a 1928 article advocating a course in obstetrics for student nurses, Frances Reed argued that there "was a great need for sound knowledge of obstetrics owing to the peculiar urgency for efficient medical care of the woman in normal labour or suffering from any of the serious complications of

³⁹ Dye, "Mary Breckinridge," 332.

⁴⁰ Dye, "Mary Breckinridge," 334-35.

⁴¹ McPherson, *Bedside Matters*, 60.

pregnancy."⁴² Reed's answer was to provide nurses with adequate obstetrical training to ensure their ability to care for parturient women. The proposed course included lectures on pre-natal examination and the physiology of pregnancy. Similar to the structure of the instruction provided to medical students, the lectures also addressed the pathology of all stages, from pregnancy and labour to puerperium. Of course, instruction was also to be delivered on the 'nursing' role, including care of infants after birth, labour room routine and ante-natal care.⁴³ The issue of midwives or providing midwifery training to nurses was not suggested outright, rather a more comprehensive course in obstetrics was outlined that was as comprehensive as one provided to medical students. The question of midwives was subsumed by a perceived professional jurisdiction that offered nurses a position at the bedside of childbirth cases in the absence of physicians.

In 1923, addressing the issue of maternal care in Ontario, registered nurse Margaret Duffield outlined the comprehensive role of the nurse in childbirth attendance. In addition to adequate obstetrical and nursing care, childbirth nurses were expected to provide:

1. Close supervision and instruction during the prenatal period.
2. Sufficient hospital accommodation for all not having good home conditions.
3. Domestic aid before, during, and after the birth, if at home.
4. Financial aid for those in poor circumstances.
5. Accurate notification of births and still-births.

⁴² Frances Reed, "A Course of Obstetrics for Student Nurses," *CN* 24, 2 (Feb., 1928), 82.

⁴³ Reed, "A Course of Obstetrics," 83.

To Duffield, nursing care was perceived as a comprehensive package that addressed the social, as well as physical, needs of the patient. Unlike physicians, who addressed the pathological aspects of childbirth, nurses infiltrated the lives of mothers and families; nurses shared the responsibility with mothers of caring and nurturing. Not only were nurses responsible for providing domestic aid, it was expected that they would find financial aid where necessary. In many ways, the nurses acted as surrogate mothers for the family, providing when a mother was unable because of confinement.

Nurses were perceived as ideal care-givers for parturient women. It was expected that they would naturally share the same concerns and desires with the mothers for whom they provided care. In writing about her attendance on a newly confined patient, Victorian Order nurse, Isabel McMann, demonstrated the maternal tone expected of female care-givers:

[T]his is one of the joys of the Victorian Order, to be able to give to this new little Canadian care in his first perilous days, guidance around the danger shoals of his first year, and later on as his friend, to teach him through his growing years habits of health that will send him out into the world sound in body and mind to take up the responsibilities developing upon every good Canadian citizen.⁴⁴

The same standards that guided motherhood were being placed upon nursing.

The emphasis on the nurturing role of nurses in public health ideology had the secondary effect of minimizing the medical role of the nurse. The emphasis in public health nursing was placed increasingly on educational campaigns and the benefits of pre-

⁴⁴ Isabel McMann, "A Day with the V.O.N.", *Public Health Journal*, 13, 9 (Sept., 1922), 420.

natal care, rather than bedside attendance. Public health and district nurses were required to direct welfare clinics, mothercraft classes, young mothers leagues and baby clinics.⁴⁵

Commenting on the necessary skills of public health nurses in Manitoba to the Canadian Nurses Association in 1918, Elizabeth Russell noted:

Our success as Public Health Nurses will depend upon our intelligence and skill, our love and understanding of children, our courage that will overcome difficulties, our tact and sympathy for the feelings and peculiarities of those among whom we work, and those less fortunate than ourselves. Our sense of humor that will relieve the commonplace, and the spirit of service that gives, expecting little in return. In addition to the virtues, the Public Health Nurse must possess teaching qualities, for her mission is to preach the Gospel of Health at all times and in all places.⁴⁶

While Russell went on to highlight the importance of knowing about hygiene and infectious disease, she did not mention a need for scientific training. Rather, the emphasis was placed squarely on the nurturing ability of nurses.

Articles relating to maternity and obstetric care reflected expectations that a physician should be the primary attendant during labour itself. A 1907 article on home obstetrical nursing by Gertrude Breslin instructed nurses to "delay delivery until the arrival of the physician."⁴⁷ Breslin went on to identify the dangers in the afterbirth period, infant asphyxiation and post-partum haemorrhaging, without discussing the actual process of labour or care of the mother; under the assumption perhaps that the doctor

⁴⁵ See Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920-25," *CBMH*, 6 (1989), 111-131.

⁴⁶ Russell, "Public Health Nursing in Manitoba," 1289.

⁴⁷ Breslin, "Obstetrical Nursing," 194.

would be tending to the labour. Nursing articles deferred to the authority of the physician with regards to confinement. "When a nurse finds upon her first visit to a patient that she has engaged a physician to attend her at the time of confinement and is under his supervision," wrote Toronto nurse Jessie M. Wood, "she gives no advice unless at request of the physician."⁴⁸ The message was clear in its absence - nurses were relegated to a "maternal" role themselves and excluded from the medicalized aspects of childbirth care.

From its inception as a professional group, nursing was plagued by a conflict between scientific professionalism and domesticity. The earliest roles accorded nurses in a sick room were based on the care-giving nature of femininity; as the primary caregivers within the family, women were believed to have a natural affinity for nursing.⁴⁹ "Their role was and often continues to be perceived by other health professionals . . . primarily as a nurturant role suited to females and mothering."⁵⁰ Further inhibiting the role of women in nursing was the delicate image accorded them by modern medicine. According to medical theory of the period, "the female nervous system was finer, 'more irritable', prone to overstimulation and resulting exhaustion."⁵¹ The delicate image of femininity

⁴⁸ Jessie M. Wood, "How the Need of Maternal Care is Being Met in Toronto," *CN* 21 (Aug., 1925), 418.

⁴⁹ Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*. New York: Basic Books, 1987, 217.

⁵⁰ Barbara Keddy, Kelly Acker, Dianne Hemeon, Donna MacDonald, Anne McIntyre, Thayne Smith, Brenda Vokey, "Nurses' Work World: Scientific or "Womanly Ministering?" *Resources for Feminist Research*, 16, 4 (1987), 37.

⁵¹ Carroll Smith Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Women and Her Role in Nineteenth-Century America," *Journal of American History*, 60 (Sept., 1973), 333.

did not necessarily harmonize with the often demanding, and very physical, labour required of nurses. As Kathryn McPherson has argued, the image of femininity often contradicted the fact that nurses were required to acquire intimate knowledge of the bodies of strangers.⁵² This remained an inherent contradiction with which nursing leadership struggled to achieve an appropriate balance.

In the case of obstetrics, the gender issue was reinforced due to the association of childbirth with mothercraft. Nurses acted as a bridge between medicine and tradition by maintaining female attendance at the bedside, but re-colouring instruction in the light of accepted scientific authority. The tasks performed by nurses under a doctor's supervision - such as bathing the patient - were seen as appropriate to the nature of femininity. However, the more medicalized tasks - such as providing medication - also were couched beneath the cloak of care-giving, rather than the art of healing. As some nursing scholars have argued, if these "treatment approaches had been used by male physicians in the hospital . . . they would probably have been considered to have been appropriately scientific for the era."⁵³ A comparison of two articles on obstetrical nursing gives evidence to this dichotomy in nursing work. Speaking before the Alumnae Association of Toronto General Hospital about obstetrical nursing at the Burnside Hospital in Toronto, W.M. Brerton employed technical language with reference to nursing duties surrounding confinement in an institution. In describing care of the perineal stitches after

⁵² McPherson, *Bedside Matters*, 35.

⁵³ Keddy et al., "Nurses' Work World," 38.

the birth, Brerton maintained a clinical tone: "Where the patient has perineal stitches we dry them carefully after the usual flushing and pack them carefully around with sterile absorbent cotton and place the bichloride pad forward over the vaginal orifice."⁵⁴ In juxtaposition, the tone adopted by Gertrude Breslin in regards to home nursing care was more relaxed and even evoked a literary reference: "The care of perineal stitches will add something more to the nurse's work after parturition, and special care should be exercised in cleansing the parts when dressings are changed. The treatment of neglected lacerations of the perineum is, as Mr. Rudyard Kipling would say "another story."⁵⁵ While it is possible to ascribe the different language to the literary style of the authors, the comparison provides evidence that typical nursing duties could be perceived in either a clinical or a domestic light.

Nursing duties straddled a very thin border between female domesticity and male science. Despite the existence of degree programs and nursing schools, they were seen as being less specialized than medical duties. The boundary between medical and domestic tasks was especially blurred in rural and under-serviced areas where nurses were far more likely to accept domestic tasks due to the isolation of communities.⁵⁶ F.C. Middleton, from the Saskatchewan Bureau of Public Health, described the conditions of pioneer women giving birth on the prairies:

⁵⁴ Brerton, "Obstetrical Nursing," 122

⁵⁵ Breslin, "Obstetrical Nursing," 194.

⁵⁶ McPherson, *Bedside Matters*, 130-31.

These women have practically taken their lives in their own hands in going into those pioneering districts where medical help, nursing assistance or hospital accommodation is possibly forty or fifty miles away. Particularly is this true when there were no telephones, few neighbours, nor roads, and oxen to travel by, or at best horses, instead of motor cars. It takes no great imaginative mind to picture a woman in labour (possibly with abnormal presentation) living in a mud or log shack, miles from any trained help, and very probably not even within reasonable distance of a neighbour woman.⁵⁷

Outlining suggestions for the problem of under-serviced rural areas, Middleton recommended home nursing courses. The Saskatchewan Public Health Bureau arranged for two nurses, specially trained as instructors, to visit rural communities offering a short course in "Practical Home Nursing" to local women. The course consisted "of lectures, on the care of the sick, diet, etc.; and practical demonstrations (on taking temperature, taking the pulse, bathing the patient, moving the patient, giving an alcohol rub, making and applying poultices and stupes, the use of the enema, and bed making)."⁵⁸ Although no obstetrical training was provided, the final day of the course was a child welfare exhibit which included "a good set of illustration cards, proper clothing for the child, proper feeding bottle, nipples, etc. Public health literature, pamphlets on the infectious diseases and a booklet specially prepared by the bureau on the "baby" are distributed."⁵⁹ Public health officials would likely never have suggested that physicians offer training courses for rural inhabitants. However, those duties associated with nursing represented a

⁵⁷ F.C. Middleton, "The Nursing Medical and Hospital Problem in the Rural West," *Public Health Journal*, 10, 7 (July, 1919), 298.

⁵⁸ Middleton, "The Nursing Medical and Hospital Problem," 300-301.

⁵⁹ Middleton, "The Nursing Medical and Hospital Problem," 301

different level of expertise that was not necessarily limited to those who attended training schools.

Reinforcing the less specialized commodity offered by nurses was the way in which physicians and nurses approached interaction with patients and developed the relationship. In a previous chapter, it was argued that physicians maintained an authoritative position over women, and often manipulated the relationship to ensure necessary compliance with medical directives. As historian Wendy Mitchinson has shown, in a patient-physician relationship, authority and paternalism were the central components.⁶⁰ Nurses, however, could not rely on any perceived authority and thus had to relate to their patients through other means. Nursing leadership often stressed tact and decorum when dealing with the modesty of mothers: "The approach to the home, and securing the interest of the prospective mother, are perhaps the most difficult problems we have to cope with," wrote one nurse.⁶¹ Practitioners were therefore encouraged to make use of their commonalities as women, rather than depend on their educational or authoritative upper-hand: "Once having gained their confidence through association with and interest in the toddlers of the family, we are told the secret of the soon-to-be-expected brother or sister."⁶² Nurses were further warned to be "careful not to injure the patient's feelings by bluntly opening the subject [of pregnancy]." It was far better to "get

⁶⁰ Mitchinson, Wendy, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1991, Chp. 1.

⁶¹ Harris, "Pre-Natal Education in the Home," *Canadian Nurse*, 20 (June, 1924), 339.

⁶² Harris, "Pre-Natal Education in the Home," 339.

acquainted on a friendly basis, such as interest many, or other members of the household."⁶³ Of particular note in the above quotes was the language used when describing the development of the nurse-patient relationship. Unlike medical journals, nursing articles referred to "friendly" interaction, finding common "interests" and simply "getting acquainted". The terms used to describe the nurse-patient relationship were directly associated with the gender commonality between nurses and mothers. The tone of the interaction was based on their association as women, rather than that of health care provider to recipient.

The gendered association, while admitting the legitimacy of nurses, ultimately served to undermine the solidification of the nursing profession. Medicine professionalised by relying on the dictates of scientific authority; nursing, though it sought to link itself to the scientific revolution, was held back by its "nurturing" character which seemed to contradict the empirical coldness of science.⁶⁴ Fighting to achieve recognized status, nurses had to address the elements of their professional identity that seemed to contradict the nature of professional organizations: "Obedience and conformity to ideals of respectable middle-class womanhood did nothing to protect student nurses from becoming the exploited drudges of an expanding hospital system nor graduates from

⁶³ Harris, "Pre-Natal Education in the Home," 340.

⁶⁴ For a discussion of the association between science and medicine, see Charles Rosenberg, *No Other Gods: On Science and Social Thought*. Baltimore: Johns Hopkins University Press, 1976, Chp. 1.

becoming insecure and ill-paid wage-earners in Canada."⁶⁵ The very characteristic that brought nurses into the medical realm limited their movements as health care providers.

This message was underscored in nursing literature relating to obstetrical care which repeatedly stressed the limits placed upon nursing. "As in all other health work," wrote Ethel Cryderman, "we naturally look to the medical profession for leadership."⁶⁶ Jessie Woods, a registered nurse in Toronto's Department of Public Health, warned readers of *CN* not to step beyond the boundaries of their professional abilities: "Adequate medical supervision by the private physician is, in our opinion, more satisfactory."⁶⁷ Self-deprecation in the face of medical authority immediately limited the role any nurse could adopt at the bedside of a parturient woman irrespective of the pre-natal work performed and the closer association of mother and nurse.

While many nursing professionals clung to the ideology that nurses provided a dual role - preventative and curative - outside of the hospital, nurses were limited theoretically to pre-natal care.⁶⁸ The gendered limitations placed on nurses in relation to maternity care led to a very narrowly defined role that relied on public health instruction as a definitive course. The capacity of the nurse in relation to maternity care was "to provide against the dangers of pregnancy and childbirth, and to keep the prospective

⁶⁵ Veronica Strong-Boag, "Making a Difference: The History of Canada's Nurses," *CBMH*, 8, 2 (1991), 237.

⁶⁶ Cryderman, "Pre-Natal Work," 536.

⁶⁷ Jessie M. Woods, "How the Need of Maternal Care is Being Met in Toronto," 418.

⁶⁸ Ethel Greenwood, "What Our Pre-natal Work Should Be," *CN*, 24, 7 (July, 1928), 364.

mother in good physical and nervous condition in order that her child may develop normally."⁶⁹

It is at this point where professional perceptions and reality become somewhat ambiguous. While the literature reinforced the authoritative role of physicians and insisted on the presence of the doctor, nurses were often the only ones present at the time of confinement. Patients could not afford the expense of a physician and families did not necessarily see the need to call a doctor because of labour. Further, some families would be at a greater distance from medical attendance, and would not wish to incur the expense of bringing out the doctor. Economical and geographic conditions would have greater bearing on the choice of birth attendant than supposed scientific evidence. Thus while the literature limited the role of the nurse, it was also forced to advocate increased training for nurses in obstetrical care. The reality was such that nurses found themselves as the only birth attendant present at the time of birth, and the journals needed to respond to the queries and concerns raised by nurses.

The perceived characteristics of nursing professionalism were heavily influenced by the methods of care adopted by nurses in relation to their patients and the community. Unlike their physician counterparts, nursing's interaction with the population extended beyond hospitals and medical offices. Public health initiatives introduced nurses into private homes, schools and community organizations.⁷⁰ Occupying the border between

⁶⁹ Cryderman, "Pre-Natal Work," 536.

⁷⁰ Strong-Boag, "Making a Difference," 243.

science and motherhood, nurses were admitted into homes as care-givers who just happened to carry medical bags. Further, among the working-classes, nurses were simply more accessible. The high cost of physician attendance would have deterred most from seeking out medical care.

Their role as front-line health reformers linked nurses more directly with political activism and social reform than the more cautious medical profession. While doctors were often leaders of the public health movement, it was nurses who adopted the principles of public health into community programs. Higher profiles as health reformers, and the gendered nature of the movement, pulled many nursing leaders into the political forum. "Unhappy with the social inequality, corruption, and inefficiency they saw around them," Veronica Strong-Boag has argued, "many nurses supported the woman suffrage movement. They joined with other progressive, largely middle-class women to demand the franchise."⁷¹

Nursing's closer association with reform and political action further narrowed the already fine line that distinguished the profession as a scientific pursuit. The principles of maternal feminism which motivated the early twentieth century suffrage advocates coincided well with the perceptions of nurses as extra-familial care-givers, reinforcing the maternal nature of nursing. Evaluating the structure of pre-natal care, Ethel Cryderman noted that support of the women's organizations was necessary in promoting the work of ante-natal nurses:

⁷¹ Strong-Boag, "Making a Difference," 243.

If organizations such as Home and School Clubs, I.O.D.E. Chapters, Red Cross Branches, Local Councils of Women, etc., would become vitally interested in the question of pre-natal supervision, and the need for maternal welfare work appeared frequently on their agenda and in the columns of their official organs, then, and only then, would the interest of the general public be awakened.⁷²

In Cryderman's eyes, nurses operated in conjunction with women's reform movements and so the perceptions of these organizations coloured the character of nursing care.

The relationship between nursing and women's organizations was felt in the broader nursing community as well. A primary example was to be found in the 1896 creation of the Victorian Order of Nurses (VON) for Canada by Lady Ishbel Aberdeen, wife of Canada's governor-general. When Lady Aberdeen participated in the 1896 annual meeting of the National Council of Women (NCW), the membership passed a resolution asking her to "found an order of nurses in Canada."⁷³ Historian Veronica Strong-Boag explored this relationship and concluded that:

Women's professions had a special role to perform in the creation of the modern community. Nursing, social work, teaching, library science and home economics, all helped to produce a more orderly, controllable and productive society. These professions, by remaining identified with the 'feminine' traits of emotionalism, self-sacrifice, culture, nurture, and spirituality helped make regimentation and supervision more palatable. . . . Male progressives were also attempting to create a more orderly community but the feminine contribution was perhaps particularly helpful in lending the transformation some appearance of humanity.⁷⁴

⁷² Cryderman, "Pre-Natal Work," 539.

⁷³ Cited from "A Century of Caring," www.von.ca/english/history.htm, April 30, 2000.

⁷⁴ Veronica Strong-Boag, *The Parliament of Women: The National Council of Women of Canada, 1893-1929*. Ottawa: National Museum of Canada, 1976, 422.

As this chapter has shown, nursing was particularly well-suited to this role given its connection to scientific authority and medical doctrine.

In their arguments in support of nursing care, childbirth attendance was a primary issue for women's organizations. At the 1917 annual meeting of the NCW, the membership heard the report of the "Committee appointed by the President to investigate the need of skilled maternity care for young mothers in the sparsely settled districts." The report, published in *CN*, argued for the need to ensure that maternity services, such as those provided by the VON, were extended to all Canadian women:

Child-bearing is a normal function, and theoretically it should not be accompanied by danger or such dreadful suffering as has been depicted. Thousands of women have not other care than they obtain from a kindly neighbor or what assistance their husbands may be able to give; women have themselves performed the necessary operation to complete the birth, and many successful births are accomplished in this way . . . It is often impossible for the mothers to stay in bed the requisite number of days. They have sometimes the care for other little ones, make bread, etc. and this frequently gives cause for serious consequences arising from displacement. . . Rich and poor of whatever nationality, in the thinly settled places of Canada, need more, better, and speedier medical and nursing care.⁷⁵

The NCW and the nursing profession expressed similar concerns with respect to child-bearing, and supported each other, as evidenced by the presence of NCW's annual reports in the *Canadian Nurse*.

The association with maternal politics by nursing ante-natal advocates was likely quite deliberate for social, and political, reasons. As historian Linda Gordon has shown,

⁷⁵ Winnifred Tilley, "Report of the Committee appointed by the President to investigate the need of skilled maternity care," *CN*, XIII, 7 (July, 1917), 430.

the maternalism beliefs wielded by social reformers were part of a broader strategy. In order to move within the male-dominated political agenda, without threatening male control, female reform rhetoric needed to be couched in subordinated terms.⁷⁶ Nurses were in a similar position. In order to solidify their own professional stature, they needed to operate within the male-dominated medical profession. This meant that their role at the bedside of parturient women could not undermine that of the physician, whose professional stature would have been equally unstable.

The strong link with the family and community was reinforced by nursing's approach to home care and childbirth attendance. "We not only believe it is the right of every child to be well born," wrote Mrs. Hannington on the Victorian Order Nurse,

but we go further and believe it is the right of every child to be born in his own house, in the bosom of his own family, as well as to be nursed at his own mother's breast - that the coming of a baby is a simple, natural process, and not an elaborate surgical operation.⁷⁷

The image of hearth and home superseded the hospitals.

Why did nurses promote a closer association with community and family not evidenced among physicians? Why would public health nurses, most often middle-class Anglo-Canadians, promote home attendance for working-class mothers when physicians repeatedly questioned the practice? Nurses, like most of the medical community, applied a double-standard to health care delivery based on class. In the case of middle-class

⁷⁶ Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890-1935*. New York: The Free Press, 1994, 55.

⁷⁷ Mrs. Hannington, "Victorian Order Work," *The Canadian Nurse* 14, 11 (Nov., 1918), 1492.

patients, home births with a physician in attendance were perfectly acceptable. The need for the nurse was not as apparent given a physician's attentions. The image, however, was not duplicated among the working-classes, who comprised a large portion of home nursing patients, but who rarely employed the services of a doctor. Both professional groups were motivated by the sources of their incomes rather than scientific theories of medicine. While interested in accessing the homes of the middle-classes, nurses were conscious of the role they played in working-class communities:

At present we reach only about one tenth of pregnant women, and the majority are not from families where living conditions are normal. This work is essential because undoubtedly it serves a purpose and keeps down the death rate. But there is a great desire to be able to work also with the keen young mother whose environment is normal.⁷⁸

The nursing leadership was conscious of public health nursing's predetermined role as care-gives to poorer urban and rural patients, and certainly interested in further developing their professional reputations among 'paying' patients. However, if all health care, especially parturient care, moved into hospital, a large scope of nursing work would be extinguished.

The motivations in support of home births would have been partially self-serving. As physicians had learned, childbirth attendance had beneficial repercussions. The advantages of home obstetrical attendance were recognized openly by the medical profession in the early days of visiting nurse services. "[T]he medical man was usually "tried out on the baby" before being admitted to the sacred precincts of the "family

⁷⁸ Cryderman, "Pre-Natal Work," 539.

physician."⁷⁹ In other words, if the mother was satisfied with the attendance she received during confinement, she would likely have relied on the same physician when her family required medical attention. The introduction of public health nursing therefore was seen by many physicians as a direct threat to their livelihood, interfering with initial contact between family and physician. Nurses developed a similar rapport with their patients: "After the nurse cared for the mother in childbirth . . . [t]he young and inexperienced mother would turn to her in small alarms, and very soon she learned to come before the child was born."⁸⁰ Parturient care was a great way to drum up business. Nurses, seeking to define their professional status, would have been favourable to continuing home attendance where patients were more directly under their care.

The scope of professional identity extended beyond defining the consumers of nursing care. Kathryn McPherson has argued that nurses were neither professionals nor working-class, but constituted their own definition of working-women - one structured by class and gender. They developed an organization model that would speak to the "realities and diversity of their workplace experience."⁸¹ As a result, they developed relationships with their patients and the communities they served which differed from that of professional physicians. This relationship was even more pronounced in public health nursing of parturient women, where nurses operated in the familiar realm of home

⁷⁹ Richard Arthur Bolt, "The Education of the Medical Student in his Relation to Child Welfare," *Public Health Journal* 9, 7 (July, 1918), 303.

⁸⁰ Hannington, "Victorian Order Work," 1412.

⁸¹ McPherson, *Bedside Matters*, 12-15.

and family, rather than in a medicalized hospital environment. Home attendance blended medical science and traditional care, paralleling the dichotomy of nursing professionalism.

Ultimately, nursing care did not threaten the role of physicians. Rather, it provided a sharper specialization for medicine by eliminating the nurturing aspects of health care from the scope of physician services. The language used in *CN* did not describe pregnancy as a pathological condition, despite such an emphasis in the *CMAJ*. On the same token, unlike occasional references in the medical journal, *CN* did not highlight the naturalness of childbirth or appear concerned with too much intervention on the part of physicians. This attitude was in keeping with the "doctor knows best" philosophy that permeated nursing literature and education.

Julia Kinnear has argued that, as the 1920s progressed, nursing fell increasingly under the jurisdiction of medicine as the leadership sought to establish a professional identity. Perceiving a general apathy among nurses towards professionalization, "a gradual shift in political alignments occurred in which the nursing leadership became further distanced from the rank and file and more closely allied with the leadership of the medical profession."⁸² How much this shift influenced nursing involvement in obstetrical care is difficult to determine. However, it is evident that in the field of obstetrical care, nursing literature increasingly promoted the educational role, as evidenced by the

⁸² Kinnear, "The Professionalization of Canadian Nursing," 155.

predominance of pre-natal and post-natal care in nursing care, over that of bedside care at the time of confinement.

* * *

The care provided parturient women by nurses obviously differed from that of physicians. Gender and professional roles coloured the translation of medical dictums, while hierarchical structures limited the position of nurses at the bedside. However, nurses acted as an important link between medical professionalism and the working-class community that contributed to a broad medicalization of childbirth. While few working-class mothers would have interacted with medical professionals, home care nurses brought the message of pre-natal care and medical attentions directly to the bedsides. The community associations of the nurses allowed them to interact directly with parturient women, a position not often accorded physicians who preferred to work among private patients or in hospital settings.

The patient load of public health and district nurses would have likely been the working-classes and the poor who were unable to afford the greater cost of medical attendance. Physicians worked in a competitive atmosphere vying for patient dollars, while nurses worked out of benevolent organizations or hospitals. Physicians would have been far more involved in the cases of paying-patients and would have more than likely provided their own ante-natal care. The distinctive class division of their respective patients undoubtedly influenced the character of care provided.

Chapter Six

"All our friends and patients know us": Obstetrical Attendance through the Margaret Scott Nursing Mission

In 1909, Mrs. M, an Italian immigrant who had been living in Winnipeg for three years, filled-in an application for confinement attendance with the Margaret Scott Nursing Mission [hereinafter MSNM].¹ Her husband, a labourer, had been out of work for months, and with three other children to feed, the family was unable to pay anything for midwifery care. So they turned to the Mission for assistance. On the day her labour pains started, Mrs. M sent for the Margaret Scott nurse. Arriving in a crisp, clean uniform with black bag in hand, the nurse immediately took charge of the household, stoking the fire and clearing the birthing room of animals and observers. The nurse made mother comfortable both physically and emotionally by attending to the needs of family members, including preparing the necessary meals and attending to the other children. When the hour of the birth approached, the nurse saw that the doctor was called and prepared the birthing room as per the doctors directives. After the birth, the nurse sponged the baby and offered Mrs. M instruction on the care and feeding of the new arrival. A few days later, the nurse returned to check on mother and baby and provide any additional instruction.

Later that same year, Mrs. C, a Canadian woman originally from the maritimes, also applied for confinement attendance with the Mission. However, her situation was

¹ The Provincial Archives of Manitoba has granted access to the files of the Margaret Scott Nursing Mission on the condition that the names of patients not be included in this dissertation. Biographical details drawn from an *Application for Nursing Attendance and Relief*, Margaret Scott Nursing Mission collection [hereinafter MSNM], Provincial Archives of Manitoba [hereinafter PAM], MG 10 B9, Box 7.

quite different. Her husband, a driver for the local butcher, earned twelve dollars a week, and the family had only one other child. Mrs C's file does not indicate the type of assistance the nurse provided, but the family did offer a donation of three dollars to the Mission.²

In total, Margaret Scott Nurses attended 367 births in 1909.³ The patient applications associated with these cases offer a rare illustration of the socio-economic backgrounds of those women who sought confinement attendance with a benevolent nursing organization. Obviously, such a narrow sampling does not represent the total patient-base of women seeking attendance in Manitoba. However, an analysis of the material available does provide a valuable glimpse at the private lives of poor and working-class urban women seeking health services outside an institutional setting.

This chapter will examine the confinement attendance services provided by the Margaret Scott Nursing Mission between 1905 and 1941⁴. The previous chapter illustrated that nursing professionals represented a distinctive approach to health care delivery; one generally characterized by gender expectations and the social confines of early twentieth century society. The MSNM was a clear example of nursing's gendered form of health care delivery. The primary work of the Mission was health care delivery

² *Application for Nursing Attendance and Relief*, MSNM, PAM MG10 B9, Box 7. The applications were not available for years prior to 1909.

³ Total of 367 drawn from the *Annual Report for 1909 of the Margaret Scott Nursing Mission*, MSNM, PAM MG10 B9, Box 6. See Appendix 1 for number of births in Manitoba from 1900 to 1940.

⁴ These years span the period in which the MSNM was in existence. It opened in 1905 and operated until 1941, when it was incorporated into the Victorian Order of Nurses.

to Winnipeg's working-class population. The organization, however, was well aware of its role as a benevolent organization. The work of the nurses was a mixture of health care delivery in the homes of patients and catering to the specific socio-economic needs of the community. The organization embodied the professional dictates of nursing professionalism. Nurses, having gained admission to homes as all around care-givers, carried the secular gospel of medicine to the bedside of patients.

With respect to childbirth cases, Mission nurses acted as a bridge between the traditional female world of childbirth and that of medicalized obstetrical care. Medically trained professionals, they brought into the homes of their working-class patients the principles of their scientific training and the beliefs of their socio-economic class. However, the reason they found themselves at the bedside of parturient women was equally related to their status as female care-givers. The Mission came into existence on the tide of female reform initiatives, and was granted funding and access to the homes of patients based on a belief in the broadening of maternal care to society at large. In this way, MSNM straddled the traditional ways of the community of women and modern science.

As has been shown in previous chapters, a rich historiography of developments in childbirth care is being cultivated in Canadian history circles.⁵ Recently, however, the

⁵ Cynthia R. Comacchio, *"Nations are Made of Babies: Saving Ontario's Mothers and Children, 1900-1940.* Montreal: McGill-Queen's University Press, 1993; Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," in Veronica Strong-Boag and Gillian Creese, eds., *British Columbia Reconsidered: Essays on Women.* Vancouver: Press Gang Publications, 1992, 143-171; Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, eds., *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and*

focus of many historians of medicine has shifted to the examination of female directed health initiatives, such as nursing organizations, in order to identify the experiences of women within health care programs. Historians have acknowledged that "women health care workers and their allies had a perspective on health care that differed from the mainstream."⁶ A recent study of nursing in Canada has argued that "nurses occupied a particular position, one simultaneously defined by class and by gender."⁷ Nursing represented a relationship between health care attendant and patient which straddled maternalism and scientific medicine. As a result, a study of nursing organizations provides new insight into the role of women as patients and as health care providers, particularly in relation to the gender segregated issue of childbirth.

The patient population cared for by the MSNM was representative of the demographic character of Winnipeg in the early twentieth centuries. Patients came from diverse socio-economic backgrounds. However, because of the Mission's mandate and location, most patients were working-class immigrants. Located in the 'North End', the

20th Centuries. Routledge: London, 1990; Cynthia Commachio Abeele, "The Mothers of the Last Must Suffer: Child and Maternal Welfare in Rural and Outpost Ontario, 1918-1940," *Ontario History* 80 (1988): 183-210; Andrée Lévesque, "Mères ou malades: les Québécoises de l'entre-deux-guerres vues par les médecins," *Revue d'histoire de l'Amérique française* 38 (été, 1984): 29; Lesley Biggs, "The Response to Maternal Mortality in Ontario, 1920-1940," unpublished M.Sc. thesis, University of Toronto, 1983; Suzanne Buckley, "Ladies or Midwives? Efforts to Reduce Maternal Mortality," in Linda Kealey, ed. *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s*. Toronto: Women's Press, 1979, 131-49.

⁶ Dianne Dodd and Deborah Gorham, eds., *Caring or Curing: Historical Perspectives on Women and Healing in Canada*. Ottawa: University of Ottawa Press, 1994, 2.

⁷ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: Oxford University Press, 1996, 9.

socio-economic make-up of Mission patients was dominated by the working classes and the poor who resided in the area.

The cultural make-up of Mission patients was also reflective of Winnipeg's eclectic urban population in the early twentieth century. By 1911, the city's population was predominantly either Canadian or British-born.⁸ However, there remained a fairly high number of individuals who represented a vast cross-section of ethnic backgrounds. Most of this non-British population was concentrated in the city's 'North End'. While those of British heritage represented 73% of the city's overall population, by 1916, British descendants only represented 39% of the North End population.⁹

The standard of living for those 'North End' immigrants was often inadequate. J.S. Woodsworth, in his role as a methodist clergyman concerned about social and economic conditions prior to WWI, wrote of Winnipeg: "It is difficult to find an actual working man's family budget which maintains a normal standard."¹⁰ The possibility of promotion was severely limited and the social aid system in Winnipeg woefully inadequate. Woodsworth remarked that:

[t]here was little chance of obtaining a foreman's position, as foreman's jobs were limited, the advancement was through favor. Public affairs was

⁸ See Chapter One.

⁹ Alan Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914*. Montreal: McGill-Queen's University Press, 1975, 158-165.

¹⁰ Cited in Artibise, *Winnipeg: A Social History of Urban Growth*, Appendix 4, 312.

largely in the hands of those looking for "graft". The church was not a factor in the situation. It was supported by wealthy men.¹¹

Further, the charity system in place rested on the principle of "worthy recipients" and thus much of the effort went into determining whether an applicant was truly in need. In 1908, the Associated Charities Board was established in Winnipeg with the intention of preventing overlapping of relief. In its 1912 report, the Board outlined what it perceived as the primary obstacle faced by relief agencies:

Unfortunately, the large majority of applications for relief are caused by thriftlessness, mismanagement, unemployment due to incompetence, intemperance, immorality, desertion of the family and domestic quarrels. In such cases the mere giving of relief tends rather to induce pauperism than reduce poverty . . . [S]ociety must make sure that the giving of it [relief] does not simply make it easier for the parents to shirk their responsibilities or lead a dissolute life.¹²

This principle of entitlement was not a uniquely Winnipeg phenomenon. As historian Linda Gordon has argued, social reformers in the early twentieth century predicated their assistance on moral reform. Thus, candidates for assistance needed to prescribe to the appropriate model and conduct. In the case of single mothers in the welfare debates examined by Gordon, the discourse moved away from the stigmatized unwed or deserted mothers to the more morally acceptable widows.¹³

The tenants of social welfare and reform, and the public voice accorded to women under its name, were important to the operation of the MSNM. In their study of the

¹¹ Artibise, *Winnipeg: A Social History*, 313.

¹² Cited in Artibise, *Winnipeg: A Social History*, 188.

¹³ Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890-1935*. Toronto: Maxwell Macmillan Canada, 1994, 25-27.

origins of the welfare states of four countries, historians Seth Koven and Sonya Michel determined that women were able to exert greater influence in the early stages of welfare policy development, while the structures were still rudimentary, and the question of social welfare still vascillated between the private and public spheres.¹⁴ Winnipeg, coping with exploding demographics and immature health care structures at the turn of the century, represented a community where women could step into the void not yet addressed by the broader political structure. Stepping into this void, the female-dominated Margaret Scott Mission was able to carve a place for itself in Winnipeg society. More importantly, the Mission established itself without threatening the male-dominated medical profession seeking to lay claim to similar ground.

Named after its founder, the history of the Mission became part of Winnipeg urban folklore. At the closing of the Mission in 1943, a newspaper eulogy revealed the community's familiarity with the Mission and its namesake:

The clop clop of a shaganappi pony's hoofs have died away from George street. The Margaret Scott Mission home at No. 99 is sold. The picture of the white haired lady who started the Mission in 1905 and made her nursing rounds with pony and trap has been taken down from the mantel and stored away in a trunk.¹⁵

The organization which bore her name was closely associated with the legend of Margaret Scott. The history of the organization, however, was equally steeped in the traditions of

¹⁴ Seth Koven and Sonya Michel, "Womanly Duties: Maternalist Politics and the Origins of Welfare States in France, Germany, Great Britain, and the United States, 1880-1920," *American Historical Review*, 95, 4 (Oct., 1990): 1077.

¹⁵ Lillian Gibbons, "The Shaganappi Pony That Went Along George Street," *Winnipeg Tribune*, May 15, 1943. Found in MSNM, PAM MG 10 B9, Box 1.

social welfare prominent in Canadian society at the turn of the century. While Scott was the centrepiece of the legend, the evolution of the Mission involved a community of social reformers, led by women, whose class and cultural beliefs fuelled their benevolent work.

On 28 July, 1855, Margaret Ruttan Boucher (1856-1931) was born into a wealthy family in the town of Colburne, Ontario. At the age of twenty-two, she met and married William Hepburn Scott, a lawyer and member of the Ontario Legislature, and settled into a predictable and respectable life as a middle-class wife. However, at the untimely death of her husband in 1881, Margaret Scott's life would adopt a radically different course, earning her the moniker "the angel of poverty row." Widowed and in need of employment to support herself, Scott obtained a clerical position with Midland Railways in Peterborough, Ontario. Five years later, in 1886, she took up employment with the Dominion Land Office in Winnipeg, Manitoba, where she met the Rev. C.C. Owen of Holy Trinity Anglican Church.

Arriving only six years after the incorporation of Manitoba as a province, Scott was struck by the plight of the immigrant poor in Winnipeg's North End, and volunteered her services for the Reverend's relief work. By 1898, she had given up her position in the Land Commissioner's Office in order to devote all her time to the work of the Winnipeg Lodging and Coffee House, a hostel for the destitute and transient. She lived with Rev. and Mrs. Owen and offered her services by visiting and counseling female prisoners and helping them find employment and residence. Eventually, she moved into the Winnipeg Lodging and Coffee House, a hostel for the destitute and transient. Despite her lack of

nursing training, she began making "rounds" among the poor offering care to the sick. Scott's work was financed by donations from wealthy patrons. Mr. E.H. Taylor, a local businessman and long-time supporter of the Coffee House, became her strongest benefactor when he offered to pay the salary of a trained nurse to assist Scott through the winter months. Upon Taylor's death, the city agreed to assume the cost of a full-time nurse, while Rev. C.W. Connor offered the funds for a second nurse.¹⁶

While Margaret Scott served as a "missionary" among the poor of Winnipeg, she was not instrumental in securing funding for the founding of a formal mission. Rather, a group of middle-class women, chaired by a close friend of Scott's, Mrs. A.M. Fraser, organized a meeting with prominent citizens and representatives from several of the city's churches on May 26, 1904. The minutes of the proceedings illustrated the social assumptions the attendees made about the immigrant poor in Winnipeg at the turn of the century, noting that the gathering was: "responding to an undercurrent movement towards a closer relation between churches and the homes of the ignorant poor in congested and unhealthy districts of the city."¹⁷ The objective, as outlined by the chairman of the meeting, John S. Ewart, a prominent lawyer and political commentator, was to:

secure a house that will answer as a central home for nurses to which application can be made, clothing and subscriptions sent, where benefits of consultation and cooperation may be had, and where women who have time and ability to devote to such work, can get first hand experience, thus

¹⁶ Biographical information compiled from article clippings held in the MSNM, PAM MG10 B9, Box 2; and, Helena Macvicar, "Margaret Scott: A Tribute", circa. 1939, MSNM, PAM MG 10 B9, Box 2.

¹⁷ *Board of Management, Minutes of Proceedings*, May 12, 1904. MSNM, PAM MG 10 B9, Box 4.

forming a band of nurses to supplement the work of the regular district nurse.¹⁸

On November 12, 1904, a second meeting was held for the purpose of selecting an advisory board, a board of directors and a board of management. At that meeting, it was resolved that membership to the Mission would be “open to all upon payment of an annual subscription fee of one dollar.”¹⁹ This fee, while relatively minor, would have immediately limited the membership of the Mission, and therefore, restricted the pool of eligible candidates to sit on the management boards. Only those with some form of disposable income would have been able to pay in order to embark on charity work. Consequently, it was likely that only middle and upper-class citizens were involved in the administration positions.

The administration of the mission, named at this meeting after Margaret Scott, was composed of a "Board of Directors, such Board to be composed of an Advisory Board of ten gentlemen with power to add to their numbers, and a Board of Management of twenty-five ladies with power to the latter to add to their number."²⁰ The representatives of the medical community were three physicians, Drs. Blanchard, Jones and Douglas, who sat on the Advisory Board. The gender division between the two boards was demonstrative of the gendered split in reform work. In her study of the National Council of Women of Canada, historian Veronica Strong-Boag has identified

¹⁸ Cited in Macvicar, “Margaret Scott,” 18.

¹⁹ Cited in Macvicar, “Margaret Scott,” 19.

²⁰ Cited in Macvicar, “Margaret Scott,” 19. For a list of individuals, see Appendix 2.

the segregated, but parallel, work of middle-class citizens involed in community leadership and social structure reform:

Professional associations, business combines and church unions were the male instruments of this transformation. The woman's club movement -- term encompassing feminine collectivities dealt with education, culture, philanthropy, reform, politics, professions and religion -- also provided many examples of the enlargement and formalization of cooperative efforts.²¹

The management of the MSNM represented this broader gendered division of social reform and benevolent work. While both the Advisory Board (all male) and the Board of Managers (all female) were involved in the organization of the Mission, including the structuring of by-laws and purchasing of land,²² the day to day operation of the Mission was left solely to non-medically trained middle-class women on the Board of Management and the nurses who served on staff. In the *Annual Report* for 1905, the officers and board of the Mission listed were all women. The staff was listed as Miss Beveridge, the nursing superintendent, three other trained nurses, two final year nurses from the Winnipeg General Hospital, a housekeeper, and Mrs. Scott.²³

A consequence of the prevalence of middle-class women in the administration of the Mission was that the cultural and class biases of the organizers rooted themselves into the treatment of poor and working-class patients. Historian Mariana Valverde has

²¹ Veronica Strong-Boag, *The Parliament of Women: The National Council of Women of Canada, 1893-1929*. Ottawa: National Museums of Canada, 1976, 2.

²² MacVicar, "Margaret Scott," 19.

²³ *Annual Report for 1905 of the Margaret Scott Nursing Mission*, 5-6. MSNM, PAM MG10 B9, Box 6.

argued that the "language of missions and of purity work reflected pre-existing power relations."²⁴ In the case of the Mission, the nurse's role within the home was not just as a care-giver, but also as a *purifier*, elevating the poor through missionary care. A description of a typical home visit by a Mission nurse was laced with assumptions about working-class families:

Here is a little shack in the North End; you might almost pass it by without noticing it, as it stands modestly back from the road, as if it was almost ashamed to be seen. We knock on the door and go in. The room is full of men and children and steam. The little girl has been washing and the damp clothes hang all around. The men (father and sons), are out of work, they say, as it is about 40 below and too cold for outdoor work. The indoor work devolves on two little girls who cannot afford to be idle. The washing and cooking has to be done, the bread made (such as it is!) and the baby cared for. We pass into the inner room where we find one of our nurses busy bathing and dressing the baby and making the mother comfortable for the day. The poor woman's eyes are sparkling as she gazes at a bright colored quilt on her bed sent by the mission. She is Polish and cannot speak English, except to say "Tank you, tank you," but her eyes show her pleasure. The baby, which had only been wrapped in dirty cotton rags before, is now washed and dressed in pretty little baby clothes which nurse has brought with her. The mother and children look on admiringly.²⁵

While not overtly critical of the living conditions of the family, the language used to describe the situation was ladden with meaning. Words such as 'ashamed', used to describe the shack, were also reflective of the writer's assessment of the family. The tone with reference to the men, who said they were out of work, juxtaposed against the image of the little girls, who could not afford to be idle, hinted at the overall impression the

²⁴ Marianna Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland and Stewart, 1991, 42.

²⁵ *Annual Report for 1907 of the Margaret Scott Nursing Mission*, 9. MSNM, PAM MG10 B9, Box 6.

writer had of the immigrant family, discreetly imposing a value judgement. However, it was the language which referred to the nurse that stood out from the above passage. In comparison to the language used to describe the family, the nurse, and the items she brought into the home, were 'bright', 'washed' and 'pretty.' The Margaret Scott nurse stood in contradiction to the squalor that bathed immigrant communities and families. As the list in Appendix 2 suggests, the administrators who ran the Margaret Scott Mission were middle-class British-Canadian, and thus fit very nicely into the model outlined by historians of the reform movement. Their role as reformers was "a discourse as much about class as about gender."²⁶ Further, social reform itself was linked to the concept of "maternal feminism" prominent among female reform organizations such as the WCTU and the YWCA.²⁷ "In confronting the working poor," concludes historian Christine Stansell, "reformers created and redefined their own sense of themselves as social and spiritual superiors capable of re-molding the city in their own image."²⁸

As a nursing organization, however, the work of the MSNM was further bolstered by the authority of scientific theory, and nurses often assumed a superior and instructive role in the homes of their patients. The language used by the nurses betrayed class

²⁶ Valverde, *The Age of Light, Soap, and Water*, 32.

²⁷ For a discussion of "maternal feminism" in Canada and the role of middle-class women in social reform see Wayne Roberts, "'Rocking the Cradle for the World': The New Woman and Maternal Feminism, Toronto 1877-1914," in *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s*, Linda Kealey, ed. Toronto: The Women's Press, 1979, 15-45; and Carol Lee Bacchi, *Liberation Differed? The Ideas of English Canadian Suffragists, 1877-1918*. Toronto: University of Toronto Press, 1983.

²⁸ Christine Stansell, *City of Women: Sex and Class in New York, 1789-1860*. Chicago: University of Chicago Press, 1987, xii.

attitudes predicated on their belief system. As a pupil nurse, J.G. Morrison condemned the conditions of home nursing service: "How can a case be conducted with such a state of affairs existing? It seems to be a desecration of the term technique."²⁹ Like her medical brethren, the nurse ascribed to a strict 'technique', whose replication was seen as difficult in the homes of patients.

The nurse's experience and training, therefore, offered her a position in the home that broke the traditional gender roles. Because of her expertise, she was allowed to manage the situation. At times, this included the role of the husband: "First of all, friend husband's hitherto useless and often frantic energies are turned into a useful channel. He is made a hewer of wood and carrier of water, also making himself indispensable in giving general information re: the hiding place of different articles."³⁰ Admittedly, the man in question was not a professional of similar social-class to the nurse. Nonetheless, in the home nursing scenario, a man acted as an assistant to a female professional - turning the tables on many preconceived notions of gender roles.

The involvement of nurses in home childbirth attendance represented a bridge between traditional birthing practices and the movement towards physician-attended, and ultimately hospitalized, birth experiences. As has been argued in the previous chapter, the care accorded by nurses, while true to the premises of scientific theory, nonetheless, represented the unique characteristics of women as primary care-givers in the family and

²⁹ *Annual Report for 1926 of the Winnipeg General Hospital*, 24. MSNM, PAM MG10 B9, Box 6.

³⁰ *Annual Report for 1926 of the Winnipeg General Hospital*, 24. MSNM, PAM MG10 B9, Box 6.

community. Nurses in the early twentieth century, graduates of an educational system firmly planted in the hospital environment and hierarchy, had been taught the importance of scientific medicine and its procedures.³¹ They undoubtedly carried such training techniques with them into the homes of patients. However, nurses also provided a type of extended care which was in keeping with their domestic roles as women. American historian Karen Buhler-Wilkinson described the blend of domesticity and scientific training in nursing care:

Good nursing care was thought to include keeping the air in the room fresh and wholesome, the patient, the patient's bed and sick room clear and quiet, establishing regularity in the giving of nourishment and medicines, skilled observation of the patient's condition, carefully recorded or communicated to the doctor, and the taking of appropriate measures to prevent the spread of contagious diseases.³²

The containment of contagion spoke to a nurse's scientific training, while the care of the room and feeding of the patient were similar to the role of any woman in the home. Historian Susan Reverby, in her study of American nursing, has referred to this dual nature of nursing work as the "dilemma of professionalism."³³

A visit from a Margaret Scott nurse exemplified the dual nature of nursing work. Many of the nurses, upon entering the homes of patients, assumed some of the domestic chores which the incapacitated mother would be unable to perform effectively:

³¹ For a discussion, see previous chapter.

³² Karen Buhler-Wilkinson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930*. New York: Garland Publishing, Inc., 1989, 28.

³³ Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945*. Cambridge: Cambridge University Press, 1987, 1.

When the neatly uniformed nurse arrives all is quickly changed. A bright fire is soon blazing; the mother is made comfortable, and the wee baby is washed and dressed; warm food is prepared; the house is made tidy; tactful suggestions are given as to better modes of management, while many bright and encouraging words are spoken, elevating to higher things. . . . Wherever the nurses go they give out their best energies, attending to the sick, chopping wood, drawing water, lighting fires, cooking food, bathing patients, dressing wounds.³⁴

While the nurse was present because of her training, her position was also firmly rooted in her identity as a woman. Consequently, the duties she assumed were reflective of her domestic role in society. As historian Kathryn McPherson has argued, "nursing relied on an image of feminine respectability to legitimate nurses' presence in the health-care system and their knowledge of the body."³⁵

It is interesting to note that by the end of 1905, the Board of Directors at the Mission had arranged for assistants to perform household chores while the nurses attended the sick and provided instruction.³⁶ In the *Annual Report* for 1905, it was noted that the "assistants to the nurses shall do the chores in the homes of the sick. . . so that the trained nurse's more valuable time may be dissipated. These helpers are, as a rule, foreigners, thus being very useful among our cosmopolitan population."³⁷ This change may have been reflective of the increased movement of nursing towards

³⁴ *Annual Report*, 1905, pp. 4-5. MSNM, PAM MG 10 B9, Box 6.

³⁵ McPherson, *Bedside Matters*, 16.

³⁶ While this is mentioned in the 1905 Annual Report, no further mention is made and it is not clear whether the assistants were staff or volunteers, or whether it was a response to nurses' demands.

³⁷ *Annual Report*, 1905, p. 5. MSNM, PAM MG10 B9, Box 6.

professionalization. Although writing about a later period in nursing history, McPherson did note that the “introduction of subsidiary patient-care attendants. . . substantially enhanced the professional standing of graduate nurses.”³⁸

Nonetheless, the role of the Margaret Scott Nursing Mission was closely associated with the feminine side of urban missionary work. Throughout its history, the Mission made furtive attempts to focus its services on straight nursing work. However, the socio-economic conditions of the area it serviced rendered the provision of nursing services impractical without social service work. As one member of the Mission noted in 1929:

In the early days of the Mission a great deal of relief was dispensed as the Social Welfare Association was not then in existence. Now only emergency relief is given, needy cases being referred to the Social Welfare Assoc. We still supply extra nourishment in cases of illness, also clothing, when we have supplies on hand. We have a loan cupboard with sheets, night-dresses, etc. The Auxiliary keep up out supplies of these articles, also making pneumonia jackets, infants and children’s clothing, etc. as required.³⁹

Despite its best intentions to provide uniquely nursing services, the Mission’s history was steeped in social welfare work.

The MSNM was strongly influenced by two broad developments in the evolution of medical history: the public health movement and the professionalization of nursing. Chapter I has already discussed the development of the public health movement, in

³⁸ McPherson, *Bedside Matters*, 226.

³⁹ Document 1213, author unknown, MSNMC, PAM MG 10 B9, Box 2.

response to societal changes resulting from industrialization and urbanization.⁴⁰ The emphasis of the public health movement encouraged government management of private health issues, creating an environment where the rhetoric of middle-class social reformers harmonized with that of medical professionals.⁴¹ As a result, the “authority of physicians spill[ed] over its clinical boundaries into arenas of moral and political action for which medical judgment [was] only partially relevant.”⁴² The focal points of public health initiatives were the medical profession, and by the 1920s, the hospital.

Coinciding with developments in public health at the turn of the century was nursing’s fledgling attempt at professionalization and the establishment of modern nurses’ training.⁴³ In Manitoba, the training revolution, which centered around moral and scientific instruction, translated into the establishment of the Winnipeg General Hospital School of Nursing in 1887. The Nursing School, located in the Winnipeg General

⁴⁰ See the introduction to the 1965 re-publication of Chadwick’s report. Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain*. Edinburgh: Edinburgh University Press, 1965. Also Benjamin Ward Richardson, *The Health of Nations: A Review of the Works of Edwin Chadwick*, volume I. London: Dawsons of Pall Mall, 1965.

⁴¹ For a discussion of the discourse of the moral reform movement, see Valverde, *The Age of Light, Soap, and Water*, 1991, 47-49.

⁴² Paul Starr, *The Social Transformation of American Medicine*. New York: Basic Books, 1982, 4.

⁴³ For a fuller discussion of nurses’ training, see previous chapter. Also see Judi Coburn, ““I See and Am Silent”: A Short History of Nursing in Ontario,” in *Women at Work: Ontario, 1850-1930*, Janice Acton, Penny Goldsmith and Bonnie Shepard, eds. Toronto: Canadian Women’s Educational Press, 1974, 135-140.

Hospital, provided a steady stream of nurses into positions across the city, including the Margaret Scott Mission.⁴⁴

Both public health initiatives and nurses' training had strong foundations in institutional culture and hierarchy by the first decade of the twentieth century. The previous chapter has already discussed the gendered hierarchical structures inherent in the professional relationships between doctors and nurses, with nurses adopting a subservient role to physicians. There were, however, other layers to institution culture, which permeated health care delivery organizations.

Canadian historian Kathyne McPherson has identified a central dichotomy between private and public patients. Private patients paid daily hospital charges and physician fees in private or semiprivate rooms. As 'customers', they had their choice of physician and received the care and attention of the staff. "Standards of gentility were more easily met on private wards wherein an upper-class domestic decor, complete with silver flatware and china dishes, was replicated, and where the patient/nurse ratio was substantially reduced."⁴⁵ Public patients, on the other hand, paid little or nothing. Consequently, they were treated in open wards with numerous other patients, and were attended by the staff members on duty.⁴⁶ If well enough, they would be expected to contribute to their own care, and that of those around them. Also, in teaching hospitals,

⁴⁴ See McPherson, *Bedside Matters*, 149

⁴⁵ McPherson, *Bedside Matters*, 81.

⁴⁶ Kathryn McPherson, "Skilled Service and Women's Work: Canadian Nursing, 1920-1939." Ph.D. dissertation, Simon Fraser University, 1989, 173 .

public ward patients could be subjected to examination by interns and medical students receiving clinical training. The attitudes of nurses towards their patients would have likely been coloured by the socio-economic background of the patients. MSNM nurses reflected their own cultural biases which were reinforced thorough nurses' training schools.

The public/private distinction extended to the type of hospital and its objectives as a health care institution. Public hospitals, the remenants of charity hospitals from early in the ninetheenth century, were governed by publicly elected boards as benevolent institutions. Further, as they relied heavily on government funds, public hospitals were often subject to state demands. Private hospitals, on the other hand, while fewer in number, were operated by independent organizations and often for profit.⁴⁷ The socio-economic status of the patient would likely have had a bearing on the duties performed by the nurse. Wealthier patients would have had a doctor to attend to all medical needs, while the nurse would have been there primarily as a care-giver. For those working in the public hospitals and wards, and out in the homes of poor and working-class patients, the doctor may not have even been present. The nurse's role, therefore, would encompass more medical-type treatments, as in the case of home maternity care.

Nurses, increasingly trained in this institutional environment, often brought the rigid hierarchical structure of hospital policies into the public health field. Margaret Scott nurses, many of whom trained at the Winnipeg General Hospital, were no exception. Upon its inception, the Mission recognized the notion that the hospital was a central

⁴⁷ McPherson, "Skilled Service," 173-74.

institution in health care delivery. "It will, of course," noted the *Annual Report* in 1905, "be borne in mind that this is auxilliary to established hospitals."⁴⁸ Throughout the history of the Mission, the nurses assumed servile roles in their relationship with physicians. While the Mission operated independently of any health care organization, many of the city's physicians attended MSNM cases free of charge. Almost all patients, therefore, were accorded a visit from a physician, many of whom held attending positions at the Winnipeg General Hospital.⁴⁹ The Mission's association with the hospital structure was further reinforced, in June of 1905, when District Nursing was added to the curriculum of the Winnipeg General Hospital School of Nursing. Arrangements were made for student nurses to receive practical training for two month periods through the MSNM.⁵⁰ This association indicated that both the Mission and the hospital shared similar views on nursing roles and expectations.

Nurses managed cases daily, but their role was always conditional. The 1938 nursing care standing orders, for example, drawn up by the Medical Advisory Committee, were "to be used only when there is no physician in attendance or when previous orders have not been left by the attending physician, in which case they should be used only until

⁴⁸ *Annual Report*, 1905, 5. MSNM, PAM MG10 B9, Box 6.

⁴⁹ The Winnipeg General was the largest hospital in Winnipeg at this time.

⁵⁰ Board of Management, "Minutes of Monthly Meeting, June 10, 1905," MSNM, PAM MG 10 B9, Box 4.

it has been possible to communicate with the physician.”⁵¹ Nursing practitioners understood the hierarchical structure of the medical system.

Public health nurses, however, were in an environment outside the rigid hierarchy of the hospital system. While they continued to ascribe to the social and class mores that they had been taught in training schools, their involvement with the family and community garnered public health nurses a more autonomous working environment. Judi Coburn, in an historical study of women at work in Ontario, noted of public health nurses: “They are noteworthy because they were much more independent than hospital or private nurses and their responsibility was often to a community rather than a hierarchic institution.”⁵² The Board of Directors, for example, was not always amenable to the requests of the Hospital. In August of 1907, the Board received a letter from a Dr. McCalman in the Department of Obstetrics at the Manitoba Medical College (affiliated with the Winnipeg General) requesting that “arrangements be made providing that students of the final year be called to cases of confinement conducted by the Nurses of their Mission.”⁵³ While the Board did not dismiss the request, the matter was put off for several months, and had not been decided upon as late as December of 1907. Ultimately, the Board accepted the hospital’s request, but not without insisting that a committee representing the Mission “meet the Doctors and consult with them on the subject, the

⁵¹ “Standing Orders,” Document 686. MSNM, PAM MG10 B9, Box 1.

⁵² Coburn, “I See and Am Silent”, 150.

⁵³ D.H. McCalman to the Board of Directors, MSNM, Aug. 9, 1907, MSNMC, PAM MG10 B9, Box 1.

committee to act at once with the power to accept or reject.”⁵⁴ The committee, composed of female members of the Board was accorded the power to reject the proposal made by a medical institution. The Board of Management never expressly voiced its concerns, but in a letter to the Board following his original request, McCalman promised that “students should not personally attend or conduct any case presenting any difficulty whatsoever. . . . In all instrumental and complicated cases one [a doctor] of experience should be called upon to do the work.”⁵⁵ Whether the Mission administration, or its nurses, were concerned about the skills of students, and the potential danger, is not certain. However, McCalman’s letter, addressing solely this issue, indicated that it was of some importance to the MSNM Board.

The minutes of the MNSM Board meeting also point to an inconsistency in the Mission’s subservient attitude towards medical authorities. Expecting full cooperation from the Mission, McCalman outlined nurses procedure for calling students to cases in a letter written in October. The Board, however, had still not made a pronouncement on the issue.⁵⁶ The evidence is clear that the Board and nurses complied with physician directives, but they were not necessarily operating on the same time-line, or with the same immediate expectations. Within the confines of the day-to-day activities of the Mission, the Board and nurses maintained a degree of autonomy. The power structure familiar to

⁵⁴ Board of Management, “Minutes of Monthly and Annual Meetings,” November 11, 1907. MSNM, PAM MG10 B9, Box 4.

⁵⁵ Letters, Aug. 9, 1907, Sept. 12, 1907, Oct. 10, 1907. MSNM, PAM MG10 B9, Box 1.

⁵⁶ D.H. McCalman to the Board of Directors, MSNM, Oct. 10, 1907, MSNMC, PAM MG10 B9, Box 1.

both doctors and nurses in the hospital setting, was not necessarily duplicated in welfare organizations. According to historian Kathryn McPherson: "The women who occupied administrative and nursing positions within private religious institutions and organizations wielded administrative and medical authority which often surpassed that of their peers in public, secular hospitals."⁵⁷ The issue of the medical students demonstrated the power negotiations which occurred outside the hospital.

The funding for the Mission was derived from a combination of public and private sources. In addition to private donations, the Mission received \$2000 from the City of Winnipeg as contribution to a building fund, and \$500 from the Province of Manitoba as start-up money. The total budget for the first year of operation was \$6753.27.⁵⁸ The city and province continued to provide significant funds to the Mission for its entire history. While the majority of funds were collected through patient fees or private donation, the MSNM, like public hospitals of the period, relied heavily on public funding (see Appendix 3). As a result of heavy state funding, some of the money was earmarked specifically for public health work identified by the city. From July 1910 until September 1914, the city provided a grant to the mission uniquely to pay the salary of a nurse to carry out child welfare work. When the city began providing district nurses for child welfare work, it

⁵⁷ McPherson, "Skilled Service," 20.

⁵⁸ *Annual Report*, 1906. MSNM, PAM MG 10 B9, Box 6.

continued the grant to the Mission to carry on work as a milk depot.⁵⁹ This is evidence that the work of the Mission was influenced by the requests of its largest contributor.

The Dominion Government also provided some funds through the Department of Immigration. Health service organizations could collect \$1.00 for each immigrant treated, if they could prove that the applicant was indeed a recent immigrant. In 1906, federal monies totaled \$291.89, but diminished to \$178.49 by 1907. Because the burden of proof was placed on the Mission, the Department of Immigration often rejected applicants based on the fact that the names did not appear on ship manifests.⁶⁰

In the summer of 1905, the Mission moved from a temporary location on Pearl Street to its permanent home on George Street. That same year an arrangement was made with the Winnipeg General Hospital whereby two student nurses from the School of Nursing served a public health training period with the Mission.⁶¹ While they wore the uniform MSNM nurses were treated with respect and admiration. When offered a police escort traveling through the more crime-ridden parts of the city, a nurse responded: "I am not afraid to go anywhere at any time in my uniform as all our friends and patients know us."⁶² While undergoing a training period with the Mission, Mary Sheppard, a graduate

⁵⁹ Board of Management, "Monthly Meetings," December 10, 1923. MSNM, PAM MG 10 B9, Box 4.

⁶⁰ "Memorandum for the Superintendent of Immigration, 1906," MSNM, PAM MG 10 B9, Box 1.

⁶¹ The number of student nurses was augmented to 5 in 1925, when the Children's Hospital provided 3 additional students in training. Dr. Ross Mitchell to Miss Beveridge, MSNM, July 30, 1925, MSNM, PAM MG10 B9, Box 1.

⁶² Cited in McPherson, *Bedside Matters*, p. 181.

of the Winnipeg General Training School, recalled being taunted by a drunken man one late night on her walk to the streetcar after a case visit. Her only reply to the man, after she had safely boarded the car, was to say firmly: "If you don't respect me, you might have respected the uniform."⁶³

In its first year of operation, 1905, the MSNM recorded 6937 visits. However, each patient was accorded more than one visit, thus the number of patients was significantly lower than the number of visits.⁶⁴ The greatest number of visits (1731) were to obstetrical patients.⁶⁵ The Mission cases were described as:

the infinite number of cases that must otherwise go to hospitals, or else be neglected - cases where a mother must remain, even in her anguish, to take care of her home, or chronics where a daily call will tide the sufferer over the day, or where the home or even the patient supplied some measure of self-help, when guided by the District Nurse.⁶⁶

More complete statistics available for 1912 also reveal that a greater proportion of MSNM cases were women and children. Out of a total of 1330 patients, 686 were

⁶³ See McPherson, *Bedside Matters*, 182 and McPherson's interview with Mary Sheppard, Winnipeg General Hospital Nurses Alumni, 1987-1988, PAM C900-941.

⁶⁴ The Annual Reports do not provide the number of patients until 1913. In that year, there was a total of 13948 visits, but only 1496 patients, making an average of 9.3 visits per patient. The ratio of visits per patient however would be highly variable since chronic and obstetric patients would receive a greater number of visits, while acute patients would more than likely receive fewer.

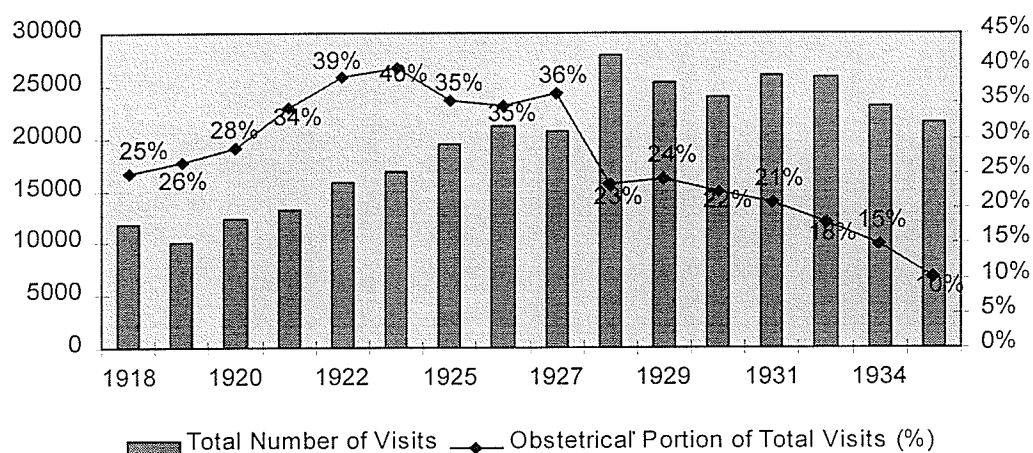
⁶⁵ There was a severe typhoid epidemic in Winnipeg in 1904-05, so 1504 of the visits were to typhoid patients. This was one of the reasons why many advocated the need for a nursing mission among the immigrant poor. By 1906, the number of typhoid visits dropped to 757. *Annual Report*, 1905. MSNM, PAM MG 10 B9, Box 6.

⁶⁶ *Annual Report*, 1905, 5. MSNM, PAM MG 10 B9, Box 6.

female, 600 were children, and only 44 were male.⁶⁷ As shown in Chart 1 Obstetrical cases invariably occupied a great deal of the Mission's time and attention.

Chart 1

Proportion of Obstetrical Visits at the MSNM, 1918 to 1941*



* Consistent sequential data only available from 1918 on.

Source: *Annual Reports, Margaret Scott Nursing Mission, 1918-1941*. MSNMC, PAM MG10 B9, Box 6.

Until the 1930s, more than 20% of nursing visits were related to obstetrical cases.

At a time when national attention was turned towards the maternal mortality rate, the conditions faced by the working-class mothers were a consistent topic in the *Annual Reports*. The nurses echoed the fears and concerns of working-class mothers. Writing in 1908, one of the Mission nurses remarked of the plight of the poor mothers under her care:

Among dirt and squalor, one finds mothers giving up their lives for their

⁶⁷ *Annual Report, 1912*. MSNM, PAM MG 10 B9, Box 6.

children, and what should be an occasion for joy, too often is looked on as a calamity, another mouth to be filled, another little piece of humanity to be clothed, when there is already scanty enough measure for the family.⁶⁸

Nurses, perhaps because of shared gendered experiences with the women they cared for, acknowledged the financial strain that childbirth had on the family. She sympathized with the mother whose responsibility was to provide for the new arrival. Unlike their medical colleagues, district and public health nurses seemed to display a better understanding of the living conditions in working-class communities. Their jobs were predicated on their ability to circumvent, or accommodate, the surroundings in order to care for the patient. With regard to confinement care, MSNM nurses recognized the limits of poor mothers in preparing arrangements for the birth. Nonetheless, they upheld the principles of their training whenever possible. As one nurse noted:

The provision made by the mother in view of coming need is often of the most inadequate description, and here the Mission steps in and does good service, lending linen, and otherwise providing for those who would be practically destitute of comfort at a time when they should have all consideration that can be given. In other cases, however, where the utmost thrift had been practiced, nothing was lacking in the preparation made and the little stranger who came, found warm hearts ready to receive him, and ample care for his comfort.⁶⁹

The expectation was that women should prepare for the births of their children, by practicing the 'upmost thrift', if necessary. However, the nurse's role deviated from that of a physician in instances where the mother was ill-prepared. The Mission, in addition to

⁶⁸ *Annual Report for 1908 of the Margaret Scott Nursing Mission*, 10. MSNM, PAM MG 10 B9, Box 6.

⁶⁹ *Annual Report for 1908 of the Margaret Scott Nursing Mission*, 10. MSNM, PAM MG 10 B9, Box 6.

providing nursing care, acted as a social welfare organization, providing linens, among other necessities for the birth.

The typical maternity case attended by a Margaret Scott nurse was significantly different from the routine they would have learned in their training. Like physicians, nurses were forced to adapt to the surrounding conditions.⁷⁰ However, unlike their medical brethren, nurses did not advocate the removal of mother from the home. Generally, they were more conciliatory to their surroundings. A student nurse described the sight of her first obstetrical case:

Nurse arrives, not preceded by the doctor, as is the case in the hospital. Probably the only light in the tiny room is furnished by a small coal-oil lamp, which burns waveringly and spasmodically, the patient lying on the low, wide, sagging bed in the corner; the nearest telephone two blocks away; absolutely no sterile dressings other than the few carried in the bag; dear me!

Household articles are found to make admissible substitutes in the absence of the proper utensils; if mother has positively only one nightie and it is essential to make a change, why, husband's best shirt is just the thing . . . What a lesson in bedside nursing is learned! Such a contrast to hospital routine.⁷¹

The tone of the nurse, dramatically different from the condemnation in the physician's voice, was perhaps related to the fact that as a woman, and a trained professional, the nurse felt a higher degree of comfort in the home. The domestic role would have been part of her job, and therefore, the duties associated with this would not have jeopardized her role as a professional. In describing a similar situation in 1924, the *Annual Report*

⁷⁰ For a discussion of doctors' impression of home births, see chapter four.

⁷¹ *Annual Report for 1926 of the Margaret Scott Nursing Mission*, 24. MSNM, PAM MG 10 B9, Box 6.

exclaimed:

Did you say, What a miserable place? How unhappy they must me! Oh no, they are not unhappy. They have each other and the baby. . . Mere things cannot make you happy or unhappy. Contentment is needed, and they are content yet full of ambition, and for their wonderful child they will struggle, and will “make good,” and in this “making good” will become good Canadian citizens.⁷²

The language focussed more on the ambitions of a missionary service - the MSNM's second role - than a nursing organization. Not suprisingly, the use of moral reform rhetoric infiltrated the *Annual Reports*. The Board of Managers who wrote the report for middle-class members, and potential donors, would have used the language familiar to their community. The issue of “Canadianizing” foreigners was common political rhetoric among members of the middle-class who addressed social problems.⁷³

Margaret Scott nurses were also involved in pre-natal and post-partum visits. Beginning in 1922, the *Annual Reports* listed the total number of pre-natal and follow up visits. While these remained a relatively small proportion of overall visits (0.5% to 3%), the 1928 addition to the regular statistics of the total number of visits to infants from maternity cases, offered a clearer picture of the amount of time nurses spent on cases related to maternity.⁷⁴ In 1928, for example, 23.4% of all visits were obstetrical, 2.5% were related to pre-natal or follow-up, and 23.9% were to maternity infants. The *Annual*

⁷² *Annual Report for 1924 of the Margaret Scott Nursing Mission*, 20-21. MSNM, PAM MG 10 B9, Box 6.

⁷³ For a discussion, see Robert Craig Brown, and Ramsay Cook, *Canada, 1896-1921: A Nation Transformed*. Toronto: McClelland and Stewart, 1974, 73.

⁷⁴ See Chart I.

Report described the breadth of maternity work, and the instructive role played by the nurse:

This work consists of following up the maternity cases that have been attended to by our regular staff, as well as cases registered at the City Hall that have been attended by midwives. On calling, the nurse examines the infant and thus learns if the child be properly bathed, clothed and nourished, and when necessary gives instructions and returns to see if they have been properly carried out.⁷⁵

The fact that the nurses involved themselves in midwifery cases was indicative of the tolerance that the medical community exhibited towards midwives.⁷⁶ It was a tolerance muted by concern. Overall, the nurse's role in the post-natal period, however, rested on teaching the mother how to mother - how to clothe, feed and bath her child. As is demonstrated in Chart 1, the proportion of obstetrical cases increased steadily until 1923, when over 40% of all visits were obstetrical. Subsequent to that year, however, obstetrical cases declined consistently. While this decrease coincided with the increase in hospitalized births, the MSNM was also coping with internal issues.

In 1935, the Mission had five graduate nurses and eight student nurses attending to the needs of its patient population. By 1937, the Board of Managers appointed a committee to review the work of the Mission, with specific emphasis on the staffing situation:

⁷⁵ *Annual Report for 1913 of the Margaret Scott Nursing Mission*, 4. MSNM, PAM MG 10 B9, Box 6.

⁷⁶ For a discussion of midwives, see J.T.H. Connor, "'Larger Fish Here to Catch Here Than Midwives': Midwifery and the Medical Profession in Nineteenth-Century Ontario," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. Ottawa: University of Ottawa Press, 1994, 104-134.

Early in the year the Board became conscious of having outgrown its dress. Changed social conditions in the city and a new consciousness of the requirements of a Public Health Nursing Service made the members realize that some reorganizing was necessary. In January, nine members of the Board were appointed to act with the Nursing Committee to act as Chairman... It was deemed advisable to call in the Superintendent of Nurses (acting) for the Winnipeg General Hospital, the Superintendent of Nurses for the Children's Hospital, as from these two hospitals came our student nurses, and the Executive Secretary for the Manitoba Association of Registered Nurses, they to form a small committee to go carefully into the nursing situation and give the Board the benefit of their experience.⁷⁷

The structural reorganization was likely a response to the criticism that the Mission had more student nurses than experienced graduates working among patients. The long-time practice of using student nurses would likely have undercut the cost of salaries for graduate nurses, especially for a benevolent organization operating in a working-class community in the 1930s. However, Kathryn McPherson has identified just such economic issues as being a primary contributor to a professional crisis in the interwar years.⁷⁸ Doubt was raised as to the ability of student nurses to adequately perform without supervision. Further, with nursing struggling to establish its legitimacy, the use of student nurses may have undercut nurses' professional positions.

After the committee was struck, the Mission replaced the entire nursing staff, revised the organization and implemented a new system of record keeping.⁷⁹ Obstetrical cases were no longer recorded in the annual reports, rather, nurses listed their ante-

⁷⁷ *Annual Report for 1937 of the Margaret Scott Nursing Mission*, 7. MSNM, PAM MG 10 B9, Box 6.

⁷⁸ McPherson, *Bedside Matters*, 115-163.

⁷⁹ *Annual Report for 1937 of the Margaret Scott Nursing Mission*, 7. MSNM, PAM MG 10 B9, Box 6.

partum, post-partum and maternity infant visits. Ultimately, the committee recommended that the permanent staff be increased by one to a total of six, and that the number of pupil nurses be decreased to one.⁸⁰ The nurses were also reminded of their role in medical care. While Mission nurses continued to attend confinements (see Appendix 1), the physicians advising the Mission reinforced their expected role in the confinement room. The Obstetrical Standing Orders for nurses drawn up by the Medical Advisory Committee in 1938 effectively omitted all reference to the actual delivery, focussing only on the pre- and post-natal care duties.⁸¹

Whether the Mission actually heeded the advice of the committee is difficult to determine. A report on the services of the Mission, written around 1941, outlined the use of student nurses as a fundamental flaw in the Margaret Scott Mission:

One of the present practices of the Margaret Scott Nursing Mission is to be frankly condemned and that is its program of accepting for training five or six student nurses... let us not forget that the primary objective of this training or exposure should always be to provide an experience of true educational value to the student nurse and not to obtain cheap service. While doubtless not by intent, the result of the student nurse training program at the Mission has been largely to obtain cheap service. That this is true is fairly well substantiated by the figures for the nursing service. The Victorian Order report for 1940 gives a total number of nursing visits of 17,356. The Margaret Scott Nursing Mission reports 17,554 nursing visits. The Victorian Order has eight field nurses, the Margaret Scott five.⁸²

⁸⁰ *Annual Report for 1937 of the Margaret Scott Nursing Mission*, 7. MSNM, PAM MG 10 B9, Box 6.

⁸¹ Medical Advisory Committee, "Standing Orders", MSNM, PAM MG 10 B9, Box 1.

⁸² Author Unknown, "Report of the Margaret Scott Nursing Mission made in Dr. Buck's Survey," circa. 1941. MSNM, PAM MG 10 B9, Box 2.

Within a year, the Mission would be incorporated into the Victorian Order of Nurses (VON).

The targets of the Mission's services during its tenure of operation, one nurse stated, were "the poorer immigrants and the foreign element."⁸³ In 1914, arrangements had been made with the Victorian Order of Nurses to ensure that the two organizations did not duplicate services. The MSNM took on only those patients who were unable to pay, while the VON took those who were able to pay their fee of 25¢.⁸⁴ In order to receive nursing attendance, prospective patients filled out an application for service (Appendix 4). The information received allowed the Mission to compile a statistical portrait of its patient population. This information was published in the annual reports beginning in 1909.⁸⁵ That year 9984 visits were made to 1192 patients. Of these, there were 181 Canadians (15%), 289 English (24%), 48 Irish (4%), 86 Scotch (7%), 17 Americans (1%), and 571 other (48%). Further, 622 were classified as Protestant (52%), 418 Roman Catholic (35%), 115 Jewish (10%), and 37 unknown (3%). Female patients represented 71% of recorded cases, while attendance of infants and sick kids represented 29% of overall visits.⁸⁶

⁸³ Author unknown, "The Margaret Scott Nursing Mission from the standpoint of a nurse of the Winnipeg General Hospital," handwritten manuscript. MSNM, PAM MG 10 B9, Box 2.

⁸⁴ Author Unknown, Document 1213, "Margaret Scott Nursing Mission." MSNM, PAM MG10 B9, Box 2.

⁸⁵ Applications are only available for the years 1908 to 1912.

⁸⁶ Of a total of 9984 visits, 2643 were classified as infants and sick kids. *Annual Report*, 1919. MSNMC, PAM MG 10 B9, Box 6.

How representative was the patient population of the MSNM of the overall Winnipeg population? In order to make a preliminary comparison, data has been drawn from the 1921, 1931 and 1941 Census of Canada and the Annual Reports from the Mission for those same years.⁸⁷ First, an examination of the gender breakdowns demonstrate that the MSNM was used most often by women. As Table I indicates, despite the fact that the city's overall population was more or less evenly split between men and women in 1921 and 1931, the MSNM drew a much higher proportion of female patients for both years. Women were the primary consumers of nursing care at the Mission. The high proportion of visits accorded to maternity cases may have been one of the reasons.

Table I

Gender Distribution, MSNM and City of Winnipeg, 1921, 1931, 1941

	Number of Male Patients, MSNM	Number of Female Patients, MSNM	Number of Males, Winnipeg	Number of Females, Winnipeg
1921	509	1329	71563	72962
1931	1519	2430	109742	109043
1941	N/A	N/A	142937	147603

Source: Census of Canada, 1921, 1931, 1941 and *Margaret Scott Nursing Mission Annual Reports*, 1921, 1931, 1941.

According to the censal material, Winnipeg citizens listing Canada as their place of birth totalled 93854 in 1921. This represented over half of the city's population.

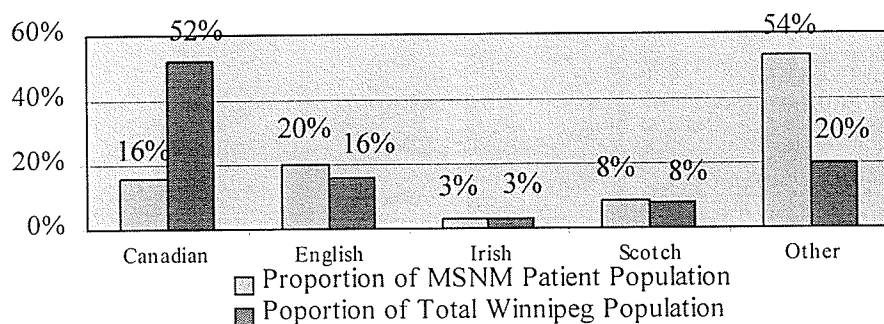
Statistics available through the Mission's *Annual Report*, however, were much more

⁸⁷ These years were chosen because of the coinciding of censal years with comparable data available in the reports.

reflective of the ethnic diversity of the North End. More than 53% of the patients attended by MSNM nurses were from countries other than the designated English-speaking nations of Canada, England, Scotland and Ireland (see Chart II). This discrepancy can be attributed partially to the location of Mission, teetering on the edge of the North End. However, the Mission patient portfolio also demonstrates a socio-economic division based on cultural and ethnic divisions in Winnipeg. Those in need of Mission care were the poorest inhabitants of the city, and the high number of non-British patients testified to the social composition of the city. The middle-class and better off working-class people - those who could afford to pay something for nursing care - were predominantly British-Canadian, while the working poor were principally foreign immigrants. The statistical data demonstrate that the patient population at the Margaret Scott Nursing Mission would have been predominantly immigrant women. The confinement attendance provided by the Mission, therefore, offers a rare glimpse into the childbirth experience of immigrant women in Canada.

Chart 2

Ethnic Comparison Between the Patient Population at the MSNM and the Overall Winnipeg Population, 1921



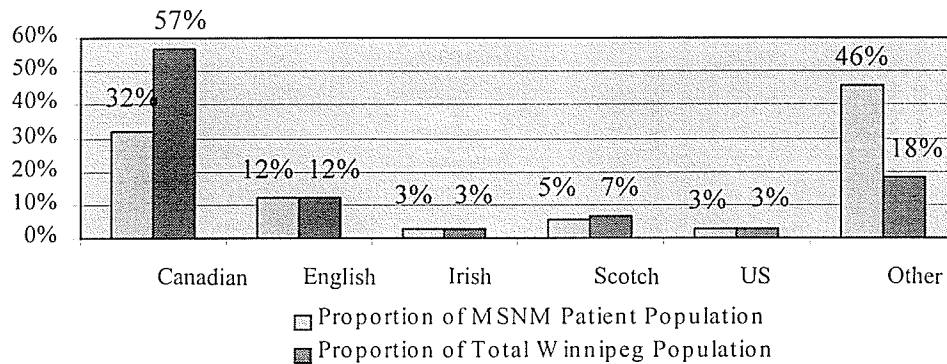
Source: Government of Canada Census, 1921, and *MSNM Annual Reports*, 1921.

The Mission continued to draw a high proportion of immigrant patients in 1931.

However, the changing character of the city was influencing the ethnicity of the North End community. The Mission treated a higher proportion of Canadian-born patients, reflecting the fact that immigration had slowed in the interwar period (see Chart III).

Chart 3

Ethnic Comparison between the Margaret Scott Nursing Mission Population and the Population of Winnipeg, 1931



Source: Government of Canada Census, 1931, and *Margaret Scott Nursing Mission Annual Reports*, 1931.

During the interwar period, as demographers Roderic Beaujot and Kevin McQuillan have demonstrated, “immigration did not make a striking impact on the country. The settlement pattern of the Prairies, involving high proportions with origins other than British or French, was established by 1914 and the immigration of the two following decades had little impact on settlement patterns in the country.”⁸⁸ As a result, Winnipeg experienced a rise in the numbers of native-born citizens, as second generation immigrant communities established families. The influence of the changing

⁸⁸ Roderic Beaujot and Kevin McQuillan, *Growth and Dualism: The Demographic Development of Canadian Society*. Toronto: Gage Publishing, 1982, 94.

demographics were felt among the North End population serviced by Mission nurses.

By 1941, the ethnic character of the MSNM patient population closely resembled that of the overall Winnipeg population. In fact, the MSNM population had a slightly higher proportion of Canadian patients than were represented in the overall Winnipeg population.⁸⁹ The alteration of the patient portfolio was attributable the shift in the city's population. The phenomenon of slowing immigration, already influencing the city in 1931, continued to shape the cultural characteristics of Winnipeg.

However, the shift in treatment focus of the MSNM also likely contributed to the shifting cultural character of the patient portfolio. The 1937 reorganization which had eliminated obstetrical cases, had also reoriented the primary focus of Mission activities. That year, chronic and long-term care patients represented the highest proportion of nursing visits. Of a total 14787 visits, chronic care consumed 4012 (27%), while post-partum and newborn care accounted for 4254 (29%) visits.⁹⁰ Previously, as has been shown, the work of the Mission was steeped in maternity and infant care, incorporating a number of young, more mobile, families, into their patient load. The increasing number of chronic care cases may have resulted in a higher proportion of elderly patients. The character of the nursing service had undergone a fundamental change, and that had a bearing on the patient base.

By the late 1930s, increased hospitalization and the decline of immigration into Winnipeg had begun to alter the patient population of the MSNM. The Great Depression

⁸⁹ See Appendix 5.

⁹⁰ *Annual Report for 1937*. MSNM, PAM MG10 B9, Box 6.

had brought the reluctant federal government into the realm of health care. As historian David Naylor has shown, to federal politicians and bureaucrats, hospitals and physicians were seen as the most efficient front line in health care delivery.⁹¹ In addition, the population surrounding the Mission was becoming more homogeneously Canadian-born as immigration lagged, and first and second generation who were more exposed to, and therefore accepting of, modern medicine. As a result, the Mission adopted more chronic care cases, while most acute patients sought attendance in hospital. Home births decreased and nurses were no longer required to provide pre-natal care, a task assumed by obstetricians as technologies advanced and promised safer deliveries. The 1942 incorporation of the Mission into the Victorian Order of Nurses showed the transformation in health care delivery. The VON offered subsidized home nursing care in collaboration with local governments and medical insurance providers.

The Margaret Scott Nursing Mission represented a clear example of a medical care delivery organization not only directed by women, but also attending to the needs of women in the community. Further, the statistics available for the Mission show that a large portion of the nurses' case load consisted of obstetrical care, including childbirth attendance in addition to pre- and post-natal home care.⁹² In keeping with the traditions of female reformers prominent in turn of the century Canada, the MSNM represented a

⁹¹ For a discussion of the involvement of the federal government in health care delivery, see David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Montreal: McGill-Queen's University Press, 1986.

⁹² The earliest statistics available are for 1905 which shows a total of 1731 obstetrical visits out of a total of 7000 visits for that year, representing 25% of the overall work load.

clear alternative to physician care for those who could not afford a doctor or simply eschewed the necessity.⁹³ As a social service organization, the Mission was typical of the Victorian health reform movement. It was administered by a group of middle-class women, with support from male professionals, and the values espoused by the organization reflected the values of British-Canadian culture.

The experiences of patients at the Mission, therefore, were representative of many across Canada who sought out benevolent attendance during childbirth. First, while the discourse which surrounded the Mission certainly had religious overtones, the MSNM did not have direct affiliation with any specific denominational church. The mission statement firmly noted that the nursing organization would not be specifically connected with any denomination in order to offer care to the many immigrants of various religious backgrounds. The Society was interdenominational, and, as expressed in one of its resolutions, co-operated "in its work with all Churches and Clergy of the City and Benevolent Associations prosecuting like or similar charitable objects."⁹⁴

Second, the objectives of the Mission often paralleled those of settlement houses such as the one pioneered by Jane Addams in the United States.⁹⁵ The nurses boarded at the Mission house in the heart of Winnipeg's Central Core, and they were encouraged to

⁹³ For a discussion of the association between the first wave of feminism and health reform see Valverde, *The Age of Light, Soap and Water*.

⁹⁴ *Annual Report*, 1905, p. 3. MSNMC, PAM MG 10 B9, Box 6.

⁹⁵ For a discussion of the settlement movement and moral /health reform see Allen Davis, *Spearheads for Reform: The Social Settlements and the Progressive Movement, 1890-1914*. New York: Oxford University Press, 1967.

make use of visits for instruction and education in addition to providing the necessary care. The nurses' presence in the community they served set them apart from health care providers associated with medical institutions. They brought their institutional training into the community, acting as a bridge between mothers and scientific medicine.⁹⁶ They also brought with them their middle-class mores and assumptions, which they often imposed on their patients, despite the obvious economic and cultural gaps. The nurses were young, single, middle-class and white; in dealing with the immigrant poor, they often demonstrated class and cultural biases.⁹⁷

Third, while the Mission had connections with the medical community - through a medical advisory board and an affiliation with the Winnipeg General Hospital, whose doctors attended MSNM cases free of charge - the Mission operated fairly autonomously. Until 1937, most decisions were left up to the staff and the Board of Managers, all of whom were women.⁹⁸ In other words, all administrative and medical decisions were left in the hands of women, and readily accepted by the larger medical community.

Lastly, a large proportion of the cases attended by Mission nurses were, in the

⁹⁶ See Charlotte G. Borst., *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge, Mass.: Harvard University Press, 1995, 118-126. Borst argues that one of the reasons general medical men practicing within ethnic communities were accepted was because they were members of that community, rather than outsiders affiliated with a unknown institution.

⁹⁷ For a discussion of the class conflict of middle-class reform organizations, see Stansell, *City of Women*, especially ch. 2.

⁹⁸ *Annual Report*, 1937, p. 11. MSNMC, PAM MG 10 B9, Box 6. It should be noted however that the Mission often consulted physicians, and were subject to the same hierarchy present in hospitals as described by McPherson, "Skilled Service," 260-62.

early years, parturient women in need of childbirth attendance. The gendered nature of the cases coloured traditional procedure and contributed to the extension of a community of women, despite the adherence to a starched medicalized environment. The role of nurses within the home often extended beyond strictly nursing care, especially in obstetrical cases. The home nursing program responded to the needs of poor women by directly addressing the fears of their patients. In addition to fears of pain and potential death when faced with childbirth, working-class women worried about the expense of medical attendance and those associated with a new baby.⁹⁹ Margaret Scott nurses not only provided medical care, they assisted with household chores and often brought food or clothing for the children.

* * *

Operating for nearly forty years as a legitimate and respected health care alternative to hospitalization in Winnipeg, the Margaret Scott Mission was perceived as part of the traditional health care network. The Mission's associations with local physicians and its teaching collaboration with the Winnipeg General Hospital demonstrate its acceptance in the Winnipeg medical community. Bred in an age of social reform, the Mission also conformed to the standards of the purity movement orchestrated by middle-class reformers who sought to inject their values into poor, often immigrant, communities. The Mission was an active, and desired, participant in health care delivery

⁹⁹ For a more complete discussion of fears associated with childbirth for working-class women, see Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918*. New York: Oxford University Press, 1993, ch. 4.

in one of Canada's largest metropolitan centers. Still, the Mission maintained its local Winnipeg characteristics due primarily to its large immigrant patient population and its locally-based administrative body.

Despite the similarities between the MSNM and contemporary medical organizations and social goals, the Mission had a perspective on health that differed from the mainstream. The gendered administrative board, staff and patient population created an environment that was predisposed to the needs of poor women, offering medical and personal attendance. As a nursing organization, the historical value of the Mission is twofold: it provides insight into the scientific developments of health care delivery, while furnishing a record of the experiences of women patients. Professionally, nursing was only beginning to adopt scientific rationale and still clung to its gendered identity of femininity and domesticity for legitimacy. Consequently, nurses maintained a connection to the women they treated which affected procedure and the management of cases. For most of their patients, Margaret Scott nurses would clean house, provide childcare or cook meals in addition to medical nursing duties. In the home of patients, these nurses had an extended role beyond that of health care delivery - an approach that coloured maternal care policy in early twentieth century Canada.

Chapter 6, Appendix 1

Total Number of Births (1900-1941) and Stillbirths (1921-1940) in Manitoba, and Total Number of Births Attended by Margaret Scott Nursing Mission Nurses			
Year	Births	Stillbirths*	Births Attended by Margaret Scott Nurses**
1900	6562		
1901	6561		
1902	6819		
1903	7800		
1904	8282		
1905	8908		65
1906	9454		
1907	11032		
1908	11695		338
1909	12255		367
1910	11721		
1911	13407		
1912	14666		404
1913	16424		459
1914	17449		288
1915	17832		325
1916	17645		
1917	14743		
1918	15317		258
1919	15091		236
1920	18322		292
1921	18478	586	354
1922	17679	566	469
1923	16472	519	520
1924	15454	495	
1925	14867	470	540***
1926	14661	416	578
1927	14147	472	582
1928	14504	473	556
1929	14236	533	539
1930	14411	481	467
1931	14376	466	445

Year	Births	Stillbirths*	Births Attended by Margaret Scott Nurses**
1932	14124	385	395****
1933	13304	364	342*****
1934	13310	369	291
1935	13335	331	
1936	12855	323	218
1937	12888	345	176
1938	13478	347	145
1939	13583	328	108
1940	14771	356	107

* Data only available beginning in 1921

** Totals not provided for every year. Some Annual Reports missing, while other do not provide number of births

*** As of 1924, the Annual Reports refer to total number of obstetrical cases

**** Statistics again refer to total number of births. This deviates slightly from the number of obstetrical cases recorded.

***** This data comes from *Clinical Reports and Statistics*, MSCMC, PAM MG10 B9, Box 2.

Source: MSNM Annual Reports, PAM MG10 B9, Box 6; Vital Statistics Agency, Consumer and Corporate Affairs, Government of Manitoba, 1996.

Chapter 6, Appendix 2

Members of the Original Board of Directors at Margaret Scott Nursing Mission, 1905

Advisory Board

Mr. W.F. Alloway
 Mr. A.M. Nanton
 Mr. G.F. Stephens
 Mr. H.H. Smith
 Mr. Thomas Robinson
 Capt. Wm. Robinson
 Dr. Blanchard
 Dr. J.R. Jones
 Dr. A.J. Douglas
 The Mayor ex-officio

Executive

Mrs. E.M. Wood, Pres.
 Mrs. J.W. Tupper, 1st V.-P.
 Mrs. Wm. Whyte, 2nd V.-P.
 Mrs. J.T. Gordon, 3rd V.-P.
 Mrs. G.D. Minty, Secretary
 Miss Vinney Riley, Asst. Secretary
 Mrs. Fred Morse, Treasurer

Board of Directors

Mrs. Margaret Scott
 Mrs. E.H. Taylor
 Mrs. J.T. Gordon
 Mrs. E.M. Wood
 Mrs. Colin Campbell
 Mrs. Wm. Robinson
 Mrs. G.D. Minty
 Mrs. Higginson
 Mrs. Moody
 Mrs. Fred Morse
 Mrs. Todd
 Mrs. Sugden
 Mrs. T. Mayne Daly
 Mrs. Oldfield
 Mrs. F.J. Sharpe
 Mrs. Stidston
 Mrs. Haggart
 Mrs. George Murray
 Mrs. Fares
 Mrs. J.H. Ashdown
 Mrs. David Flemming
 Mrs. D.C. Cameron
 Mrs. W.J. Tupper
 Mrs. Manlius Bull
 Mrs. Sanford Evans
 Mrs. Bond
 Mrs. William
 Mrs. Whyte
 Mrs. J.S. Aikins
 Miss Drummond
 Miss Brunsterman
 Miss Vinney Riley

Chapter 6, Appendix 3

Public Funding Received by the Margaret Scott Nursing Mission, 1905 to 1941

Year	Total (\$)	City of Winnipeg (\$)	Government of Manitoba (\$)	Immigration (\$)	Proportion of Public Funds
1905	6753.27	2000	500		37%
1906	7101.35	2400	500	291.89	45%
1907	6395.22	2400	1000	178.49	56%
1908	6434.97	2400	500	121.99	47%
1909	6247.59	2400	500		46%
1912	7624.71	1600	1000	133.5	36%
1913	9585.86	3000	1000	172.5	44%
1914	8537.08	3000	1000	190.5	49%
1915	9217.97	3650	2000	13.5	61%
1918	8779.46	2400	1500		44%
1919	10697.99	3600	1500		48%
1920	11456.93	1600	1500		27%
1921	14023.75	3600	1500		36%
1922	14545.76	3600	1500	39.75	35%
1923	15552.11	3600	1500		33%
1925	17285.72	3600	1749.99		31%
1926	18010.48	3600	2250		32%
1927	21881.78	3600	1500		23%
1928	22106.74	3600	1500		23%
1929	16814.77	3600	1500		30%
1930	24218.98	3600	1500		21%
1931	25405.13	3600	1500		20%
1932	11882.24		750		6%
1934	15881.39	4920	675		35%
1936	16297.25	3710	675		27%
1937	13140.3	3600	675		33%
1938	14257.73	3600	675		30%
1939	12947.86	3600	675		33%
1940	13246.36	3600	675		32%
1941	12526.74	3600	675		34%

Source: *Annual Reports of the Margaret Scott Nursing Mission, 1905-1941.*
MSNMC, PAM MG10 B9, Box 6.

Chapter 6, Appendix 4

Margaret Scott Nursing Mission

Application for Nursing, Attendance and Relief

Name.....

Address.....

Nationality.....

Church.....

Married or Single.....

Number of Children and Respective Ages.....

Occupation, Man.....Amount per Week, \$.....

Occupation, Woman.....Amount per Week, \$.....

Nature and Duration of Sickness.....

Property Owned or Rent Paid.....

Period of Residence in the City.....

Period of Residence in Canada.....

How Assisted.....

Number of Visits.....

Doctor Attending.....

Source: Applications for Nursing Attendance and Relief, 1908-1912. MSNMC,
PAM MG 10 B9, Box 7-10

Chapter 6, Appendix 5

Ethnic Comparison Between the Patient Population at the MSNM and the Overall Winnipeg Population, 1921

	Ethnicity of MSNM Patients	Proportion of MSNM Patient Population	Birth Place of Winnipeg Population	Proportion of Total Winnipeg Population
Canadian	375	15.6%	93854	52.4%
English	476	19.8%	28546	15.9%
Irish	66	2.7%	5784	3.2%
Scotch	201	8.4%	14580	8.1%
Other	1289	53.6%	36323	20.3%

Ethnic Comparison between the Margaret Scott Nursing Mission Population and the Population of Winnipeg, 1931

	Ethnicity of MSNM Patients	Proportion of MSNM Patient Population	Birth Place of Winnipeg Population	Proportion of Total Winnipeg Population
Canadian	1257	31.8%	123634	56.5%
English	469	11.9%	26161	12.0%
Irish	109	2.8%	5741	2.6%
Scotch	209	5.3%	14719	6.7%
US	99	2.5%	5902	2.7%
Other	1806	45.7%	39537	18.1%

Ethnic Comparison between the Margaret Scott Nursing Mission Population and the Population of Winnipeg, 1941

	Ethnicity of MSNM Patients	Proportion of MSNM Patient Population	Birth Place of Winnipeg Population	Proportion of Total Winnipeg Population
Canadian	1139	68.5%	191989	66%
British	204	12.3%	51914	18%
U.S.	17	1.0%	6760	2%
European	280	16.8%	38919	13%
Latins	3	0.2%	54	0.02%
Oriental	3	0.2%	831	0.3%
Others	17	1.0%	46	0.02%

Source: Government of Canada Census, 1921, and *MSNM Annual Reports*, 1921, 1931, 1941.

Conclusion

"Men and women are unequally affected by sex. The male is only male at times; the female is a female all her life and can *never forget her sex*."

- Jean-Jacques Rousseau, *Emile, or On Education* (1762)

By the end of the twentieth century, childbirth became a fully medicalized process. As of the 1940s, more than half of registered Canadian births occurred in hospital. Today, home births are rare, and at a minimum even they involve some contact with an obstetrician during pregnancy. However, the transition of childbirth from the private world of the mother to the public world of the physician was a lengthy and heavily negotiated procedure. Physicians had begun their association with childbirth in the mid-nineteenth century, but it would take several decades before the profession and the public recognized parturient care as a medical specialty. Ultimately, the efforts of both physicians and nurses - and their dealings with female patients - helped lead to the medicalization of childbirth.

The childbirth experiences of Canadian women were not homogenous. The type of care a woman sought out for her confinement would have been influenced by a myriad of circumstances - including, among others, age, geographic location, health, cultural background and socio-economic status. Thus, an examination of the approaches used by both physicians and nurses in a prairie city can only purport to be partially representative of the Canadian experience. What such a study can provide, however, is a degree of insight into the everyday events of an age long past. Social history grapples with telling the stories of those omitted from the historical record. A study of the childbirth experiences of mothers in one prairie town responds in some way to that struggle.

Despite its limitations, the city of Winnipeg does suggest a distinctive example of urban Canada at the turn of the century. It was a city at the forefront of modernity that also clung to its western pioneer heritage. Its medical men were fully conscious of developments in modern medicine and strove to establish contemporary services and institutions. This environment allowed for a degree of choice in care-giving, especially among mothers seeking safer childbirth experiences. The medical profession shared similar approaches and goals to physicians elsewhere in the country, as evidenced in the pages of the *Canadian Medical Association Journal*, which were translated into contemporary treatment techniques. At the same time, the city maintained a pioneering character that gave rise to more traditional forms of attendance for those who could not afford, or did not perceive the need for, physician attendance during childbirth. “While the medical profession, women’s organizations and governments sorted out which solution was best,” concludes Nanci Langford, “many homestead families were left to cope on their own.”¹

Winnipeg’s population was a cross-section of immigrants, frontiers-people and established middle-class entrepreneurs. It was also home to a multinational hodgepodge of citizens, from a variety of socio-cultural backgrounds. The women who gave birth in this town were representative of the overall population. An analysis of their experiences offers a breadth of subjects perhaps less easily found in the more economically and culturally homogenous surroundings of eastern Canada.

¹ Nanci Langford, “Childbirth on the Canadian Prairies, 1880-1930,” *Journal of Historical Sociology*, 8 (1995), 198.

Along the way to medicalization, concerns about childbirth would move from the private homes of mothers to the public domain of social reformers and medical professionals. The worry and fears about debility and death were constant for women. However, the high cost of maternity entered public debate in the early twentieth century only when social reformers couched the issue in nationalistic terms. In the years surrounding the Great War, the losses of infants and mothers were recognized as losses to the nation, and public debates swarmed around the issue of maternity care.

Aligning their arguments with the budding reform rhetoric, physicians developed a niche for medicine, and especially the young specialty of obstetrics. Throughout the late nineteenth century, doctors struggled to establish professional stature within the middle-classes of Canadian society. The public was only beginning to recognize the 'virtues' of modern medical science, and many remained aloof to the curative powers of medical men. This notion was reinforced in the area of childbirth where physician knowledge extended not much further than that of local midwives. While doctors had some access to maternity training, obstetrical training and experience were often limited in medical curricula. The limited experience that was available to young doctors was only in a hospital setting; an environment which ill-prepared them for the realities of home birth techniques. Nonetheless, physicians, recognized the valuable connections which could be achieved through confinement attendance. Not only could it create a business opportunity, successful attendance of mothers allowed for an important link to middle-class families.

The issue of obstetrical care was prominent in the pages of medical journals. Throughout the period under investigation in this dissertation, physicians maintained ongoing debates about obstetrical techniques and the profession's role. The issue of maternal mortality, however, remained a constant. Doctors - whatever their positions with respect to techniques such as the use of drugs, the involvement of a midwife, or pre-natal care - were united in their belief that medicine would be able to find the 'cure' for high death rates among Canadian mothers. Publications such as the *Canadian Mother's Book* and the *Pre-Natal Letters*, written by doctors but addressed to the public, underscored a faith in the abilities of the profession.

While the male-dominated medical profession had a significant role, women were also involved in bringing about the medicalization of childbirth, both as patients and professionals. Fearful of any number of potential ills which could befall them during a pregnancy, those women who could afford it appear to have been pleased to avail themselves of the promises of modern medicine. From anaesthesia to instruments, women recognized the potential of science to alleviate some of the chronic pain and suffering associated with childbirth. The desires of female patients were evidenced in the pages of medical journals and in the treatment techniques adopted, or rejected, by physicians in reaction.

It was nurses, however, who provided the greatest mediative role in the medicalization of birth. Seeking to legitimize nursing as a profession, nurses sought to identify a role for themselves which clung to the principles of Victorian femininity. They structured their role at the bedside of patients within the realm of care-giver, always

subservient to male medical experts. They were, however, professional care-givers. Their techniques were based in the rigid training of scientific medicine, but their duties were part of the traditional community of women who came to assist in confinement. Consequently, nurses moved easily between two distinctive worlds. In so doing, they brought the secular gospel of medical science and public health to the bedside of patients. Nurses, therefore, opened the gateway through which physicians ultimately stepped to bring about the medicalization of childbirth by the middle of the twentieth century.

Writing about the education of a young female pupil, Rousseau laid down a premise which seems particularly appropriate for the history of childbirth in Canada. While a “male is only a male at times,” noted Rousseau, “the female is a female all her life and can *never forget her sex*.” Childbirth was a constant reminder for women that they could not escape their femininity. The ‘scientization’ of a traditional female world highlighted Rousseau’s contention that men (physicians) could step in and out, but that women (mothers and nurses) would always be relegated to a maternal role.

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