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

Marion Lynne Clark McKay

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

Doctor of Philosophy

Department of History
University of Manitoba
Winnipeg, Manitoba

2005

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION

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

BY

Marion Lynne Clark McKay

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

Doctor of Philosophy

Abstract

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

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

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

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

Acknowledgments

It is a great pleasure to have finally completed a study of a subject that first captured my interest when I was an undergraduate nursing student in the early 1970s. Many people have assisted me over the years. Dr. Gerald Friesen served as my advisor for both my MA and PhD studies, and has been unfailingly patient and helpful. I thank him, not only for these qualities, but also for the high standards that he set and for his confidence that I could attain them. I also thank the four members of my examining committee. Dr. Tamara Myers and Dr. James Hanley, both members of the History Department of the University of Winnipeg, have been teachers and mentors in the best sense of those words. Dr. Evelyn Forget, Faculty of Medicine, University of Manitoba, provided thoughtful comments and questions. Dr. Wendy Mitchinson , History Department, University of Waterloo, was an outstanding external examiner. Her careful reading of the thesis and the challenging questions she posed will shape my ongoing work in the history of public health. Many thanks also to the faculty and staff of the history departments of both the University of Manitoba and the University of Winnipeg for their interest and encouragement during my studies.

I also thank my colleagues and friends in the Faculty of Nursing. In an workplace where many of us, both support staff and faculty, struggle to pursue academic studies, earn a living, and fulfill personal and family responsibilities, one is always able to find wise counsel, good fellowship, and a shoulder to lean on. Dr. Janet Beaton and Dr David Gregory were both very supportive during their respective terms as Dean. Jackie Dewar helped me untangle the mysteries of the VON's financial statements. The Manitoba Nursing Research Institute provided valuable technical support, and I particularly thank Diane Cepanec, Stephanie Kasdorf, and Amanda Dietrich for their work in designing the necessary databases and entering the demographic data contained in Chapter 6.

The Manitoba Association for the History of Nursing, the Canadian Association for the History of Nursing, the Manitoba Society for the History of Medicine and the Canadian Society for the History of Medicine encourage scholarship in the history of health care. I have appreciated the intellectual and personal support that members of these organizations have provided to me. I am also grateful for the interesting discussions about *M. bovis* with Dr. Terry Whiting, Veterinary Disease Control & Epidemiology, Veterinary Services Branch, Manitoba Agriculture & Food.

I recall with great pleasure the many hours I spent working in various archival collections in the city. Thanks to the staff at the Archives of Manitoba and the City of Winnipeg Archives for their interest in my research and for their considerable help in locating and, in some cases, negotiating access to the documents I needed. I thank Darlene Demkey, FIPPA Coordinator for Manitoba Health, for her role in overseeing my access to that department's records. Any opinions and conclusions contained in this thesis are mine and have not been endorsed or approved by the Government of Manitoba. Many

thanks also to Anne Crossin, volunteer archivist of the Nurses Alumni Association Winnipeg General Hospital/Health Sciences Centre Archives for her assistance. Lori Fenn of the Manitoba Branch, Victorian Order of Nurses, helped me locate the remaining records of Winnipeg Branch of the VON, and Margaret Mackling generously shared these documents with me despite the fact that she was hard at work writing a history of that organization.

I received much appreciated financial support, including a three year doctoral fellowship from the Social Sciences and Humanities Research Council, and the Dr. James Burns Award in History from the University of Manitoba.

Last, but not least, I thank my friends and family for their steadfast support during my studies. I owe a debt of gratitude to my husband Allan and my son Andrew for all that they have done to encourage and inspire me, and I dedicate this thesis to them.

Table of Contents

Abbreviations

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

List of Illustrations

Figures

Tables

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

James E. Reeves
APHA President, 1885

Chapter 1

Introduction

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

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

---

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

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

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

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

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

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

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

---

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

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

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

Rationale for the Study

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

---

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

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

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

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

---

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

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

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

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

---

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

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

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

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

---

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

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

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

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

---

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

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

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

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

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

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

---

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

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

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

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

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

---

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

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

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

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

---

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

[17]Bliss, *Plague*.