NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.
SKILLED SERVICE AND WOMEN'S WORK:
CANADIAN NURSING, 1920-1939

by

Kathryn Mae McPherson
B.A. (Hons), University of Winnipeg, 1979
M.A., Dalhousie University, 1982

Thesis Submitted in Partial
Fulfillment of the Requirements
for the Degree of Doctor of Philosophy
in the Department
of
History

© Kathryn Mae McPherson, 1989
Simon Fraser University
December, 1989.

All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.
The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-66222-0
APPROVAL

NAME: KATHRYN MCPHERSON

DEGREE: PH.D.

TITLE OF THESIS: SKILLED SERVICE AND WOMEN'S WORK: CANADIAN NURSING, 1920-1939

EXAMINING COMMITTEE: CHAIR: DAVID ROSS

VERONICA STRONG-BOAG,
SENIOR SUPERVISOR
HISTORY DEPARTMENT

MARY-LYNN STEWART
ASSOCIATE PROFESSOR
HISTORY DEPARTMENT

JOHN HUTCHINSON, PROFESSOR
HISTORY DEPARTMENT

ALLEN SEAGER, ASSOCIATE PROFESSOR
HISTORY DEPARTMENT

ARLENE MCLAREN
ASSOCIATE PROFESSOR
SOCIOLOGY/ANTHROPOLOGY DEPT
SIMON FRASER UNIVERSITY

ANDREE LEVESQUE
ASSOCIATE PROFESSOR
HISTORY DEPARTMENT
MCGILL UNIVERSITY

DATE APPROVED: December 15, 1989
I hereby grant to Simon Fraser University the right to lend my thesis, project or extended essay (the title of which is shown below) to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users. I further agree that permission for multiple copying of this work for scholarly purposes may be granted by me or the Dean of Graduate Studies. It is understood that copying or publication of this work for financial gain shall not be allowed without my written permission.

Title of Thesis/Project/Extended Essay

20th Century Canadian Women's History Skilled Service and Women's Work: Canadian Nursing, 1920-1939

Author:

Kathryn McPherson

December 15, 1989

(signature)
ABSTRACT

Skilled Service and Women's Work:
Canadian Nursing, 1920-1939

This thesis examines the experiences, attitudes and actions of the women who trained and worked as graduate nurses during the 1920-1939 years -- of the third generation of hospital-trained Canadian nurses. The 1920s and 1930s were decades of crisis for Canadian nursing, and the occupation's majority, working in the private duty sector, was most severely affected by the problems of oversupply and underemployment. The economic crisis was national in scope, and endemic to the health care system, and was therefore exacerbated rather than created by the depression of the 1930s. In order to analyze the structure and content of the occupation during these years of crisis, a wide variety of national sources were consulted, supplemented by a detailed case study of nursing in the prairie metropolis of Winnipeg, Manitoba.

This thesis argues that the third generation of Canadian nurses was recruited from an elite sector of the sex-segregated female labour market. The many rituals and routines which constituted nursing technique were based on a theoretical understanding and practical application of the germ theory. As such, nursing practice during the interwar years must be defined as scientific. Nurses' scientific skill permitted practitioners to integrate caring and curing, and thereby to create their own definition of what constituted skilled service. Out of this self-definition came a specific occupational identity which was reflected in the many associations designed to represent nurses' interests. As the interwar decades progressed, conflict developed within nursing organizations as to appropriate solutions to the economic crisis.
The compromise solution, hospital employment of graduate nurses, initiated the demise of both the apprenticeship system of hospital staffing, and private duty nursing. This solution successfully prevented the fracturing of nursing organizations during the 1920s and 1930s, but also facilitated the transformation of hospital staffing which would occur during the World War II years.

This research on Canadian nursing during the 1920s and 1930s adds another chapter to the growing scholarly literature on Canadian women and work. It also contributes to the secondary literature on the social history of medicine and of labour in two particular ways. First, as the largest health care workforce, the actions of graduate nurses during the 1920s and 1930s, their agency, served as a critical force within the development of the Canadian health care system, a force frequently overlooked within medical history. Secondly, the third generation of Canadian nurses' borrowed from the organizational strategies of both professionals and trade unions, but neither concept fully captured the reality of nurses occupational identity as women and as workers. This research suggests that the scholarly literature on professionalism, and on labour organizations, must more fully account for gender as a historical determinant. In suggesting a historical periodization for Canadian nursing history, and in focussing on the third generation of Canadian nurses who struggled through the economic crisis of the interwar decades, this thesis contributes to the growing body of scholarly literature dedicated to placing nursing history in history.
DEDICATION

This thesis is dedicated to Marion Florence Mathieson who showed me the dignity and glamour of a working woman.
ACKNOWLEDGEMENTS

Over the past five years, many people have assisted in the completion of this thesis.

My family has consistently offered love and support throughout my education. My parents, Margaret and Murray McPherson, provided moral, financial, editorial and clerical assistance, and shared with me their personal knowledge and affection for the urban and rural communities of my study. Most importantly, they taught me that learning was fun. As well, Jack, Christie, Meghan, Andrew and Daniel McPherson proffered hospitality and relaxation during my many retreats to Winnipeg.

Warm thank-you’s are extended to Mike Gasher, Frank Luba, and Heather McLeod for their patience and persistence through many years of discussions and editorial sessions. The intellectual and emotional support of Hotel East 10th has been greatly appreciated, even though I still can't "say it in one sentence!" Debbie Huband, Patti Fassbender, Rini Sladecek, Sandy Pothier, Malcolm Smith, Colette Hogue, Susan Riddell, Kathleen Edmunds, Peter Van Drongelen, Mike Miller and Perrie Scarlett all volunteered clerical, computer and motivational help. Judith Allen, Doug Cruikshank, Gina Feldberg, Margaret McPherson, Linda Peake, Joanne Whittaker, and the Vancouver Labour History Group read parts of this thesis, and contributed useful comments and suggestions.

I would also like to acknowledge the financial assistance of the following: Simon Fraser University Open Graduate Scholarship; Simon Fraser University President's Research Scholarship; Canadian
Federation of University Women Margaret McWilliams Doctoral Fellowship; Social Sciences and Humanities Research Council Doctoral Fellowship; and the Province of Manitoba Ministry of Culture, Heritage and Recreation Oral History Grants Program.

I feel privileged to have had the thesis supervision of Dr. Veronica Strong-Boag. The direction, respect and confidence she provided throughout my doctoral program created a feminist framework within which to work and learn. The volunteer archivists of nursing associations across the country graciously donated their time and information. Particular credit is due to Elaine Tresoor of the Winnipeg General Hospital Nurses’ Alumnae Association. And finally, much gratitude is extended to the many Canadian nurses of the third generation who opened their homes to me, sharing their memories and mementoes of the history they have lived. All errors and omissions are my own.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>i</td>
</tr>
<tr>
<td>Approval Page</td>
<td>ii</td>
</tr>
<tr>
<td>Abstract</td>
<td>iii, iv</td>
</tr>
<tr>
<td>Dedication</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi, vii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>viii, ix</td>
</tr>
<tr>
<td>List of Figures</td>
<td>x-xii</td>
</tr>
<tr>
<td>Chapter 1 Introduction</td>
<td>1-33</td>
</tr>
<tr>
<td>Notes</td>
<td>34-45</td>
</tr>
<tr>
<td>Chapter 2 Placing Nursing History in History</td>
<td>46-80</td>
</tr>
<tr>
<td>Notes</td>
<td>81-92</td>
</tr>
<tr>
<td>Chapter 3 An Occupation in Crisis</td>
<td>93-148</td>
</tr>
<tr>
<td>Notes</td>
<td>149-162</td>
</tr>
<tr>
<td>Chapter 4 Tripping Down An Alluring Path Into</td>
<td>163-227</td>
</tr>
<tr>
<td>A Garden of Great Adventure In Private Duty Nursing:</td>
<td>163-227</td>
</tr>
<tr>
<td>Winnipeg As A Case Study</td>
<td>228-246</td>
</tr>
<tr>
<td>Notes</td>
<td>228-246</td>
</tr>
<tr>
<td>Chapter 5 Rituals and Resistance:</td>
<td>247-314</td>
</tr>
<tr>
<td>The Content of Nursing Work</td>
<td>247-314</td>
</tr>
<tr>
<td>Notes</td>
<td>315-330</td>
</tr>
</tbody>
</table>
Chapter 6 "Trade Unionism of the Worst Type": Nursing Organizations and Women's Work 331-385
Notes 386-399

Chapter 7 Conclusions: "The Price of Generations...." 400-415
Notes 416-417

Appendix A 418

Bibliography 419-449
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Canadian Training Schools Established Prior to 1900</td>
<td>9</td>
</tr>
<tr>
<td>1.2</td>
<td>Pre-1940 Work Experience of WGH Interview Sample</td>
<td>30</td>
</tr>
<tr>
<td>3.1</td>
<td>Number of Women Workers, and Nurses, Canada, 1891-1941</td>
<td>99</td>
</tr>
<tr>
<td>3.2</td>
<td>Distribution of nurses by province, 1921, 1931, 1941 (women)</td>
<td>101</td>
</tr>
<tr>
<td>3.3</td>
<td>Ratio of Nurses to Population Canada and the Provinces</td>
<td>103</td>
</tr>
<tr>
<td>3.4</td>
<td>Marital Status of Nurses, by Occupational Sub-sector, 1929-1930</td>
<td>105</td>
</tr>
<tr>
<td>3.5</td>
<td>Marital Status of Nurses, Canada 1921-1941</td>
<td>106</td>
</tr>
<tr>
<td>3.6</td>
<td>Birthplaces of Nurses, Canada, 1921, 1931</td>
<td>107</td>
</tr>
<tr>
<td>3.7</td>
<td>Ages of Nurses, Canada, 1921-1941</td>
<td>109</td>
</tr>
<tr>
<td>3.8</td>
<td>Age Distribution of Women Workers, Canada, 1931</td>
<td>110</td>
</tr>
<tr>
<td>3.9</td>
<td>Comparative Age Distribution, Five Female-Dominated Occupations, Canada, 1931</td>
<td>111</td>
</tr>
<tr>
<td>3.10</td>
<td>Occupation of Nurses' Parents or Guardians, 1929-1930</td>
<td>113</td>
</tr>
</tbody>
</table>
3.11 Cases Accepted by Nurses, Canada, 1929-1930 121
3.12 Average Time Spent, Private Duty Nurses, 1929-1939 126
3.13 Average Time Spent, Institutional Nurses, 1929-1930 127
3.14 Average Time Spent, Public Health Nurses, 1929-1930 127
3.15 Average Time Spent, Superintendents, 1929-1930 128
3.16 Annual Average Income, Canada, 1929-1930 128
3.17 Annual Income by Province, 1929-1930 129
3.18 Estimated Cost of Living, Canada, 1929-1930 131
3.19 Average Annual Earnings, Female Employees
Bank of Nova Scotia, Manufacturers Life
Insurance Company, 1926 & 1931 133
3.20 Ages of Nurses by Sub-sector, by Province 129-1930 140
3.21 Work Experience of Public Health Nurses, Canada, 1929-1930 141
3.22 Anticipated Destination of Nurses
Leaving their Sub-sector 143
3.23 Distribution of Nurses by Sub-sector 146
4.1 Death Rates from Communicable Diseases, Winnipeg, 1920-1939 169
4.2 Distribution of Schools of Nursing, By Provinces, 1931 and 1935 175
4.3 Public Hospitals in Winnipeg, 1933

4.4 Winnipeg General Hospital, Ratio of Patients to Nurses, 1919-1939

4.5 Graduates of Manitoba Schools of Nursing Gaining RN Status, 1925-1937

4.6 Hometowns of Winnipeg General Hospital Graduates, 1924-1939

4.7 Women Working in Selected Occupations as Per Cent of All Women Workers, Winnipeg and Manitoba, 1936

4.8 WGH Graduates, 1920-1928, Never Married, and Married Within 1, 3, 5, 10 years and More than 10 Years of Graduation

5.1 Excerpt from Myrtle Bowman, Notebook 1928-1931

6.1 Original Members of the CNATN

6.2 Dates of Provincial Registration Acts
Chapter 1
Introduction

In the history of women's wage work, nursing holds a special place. Once the responsibility of informally-trained family, friends, or members of religious orders, nursing was transformed in the late nineteenth century from unpaid care to wage labour, and in its modern form the occupation took on new appeal. For historians, this transformation has produced charismatic individuals worthy of scholarly study; individuals such as Florence Nightingale, Edith Cavell and Sister Kenny have loomed large in international historiography.¹ For the creators and consumers of popular culture, the image of the modern nurse has spawned characters as diverse as Charles Dickens' "Sarah Gamp" and Ken Kesey's "Big Nurse", within genres ranging from adolescent literature to Harlequin romance novels to pornography.² For architects and artists, nursing provided powerful feminine imagery.³ For "first wave" feminists, nursing promised a separate sphere in which women could attain financial and personal independence. For women needing and wanting work, nursing offered (and offers) relatively decent wages, a non-industrial work environment, public respect, geographic mobility and the option of leaving and rejoining the paid workforce without substantial penalty. For contemporary enthusiasts of their family histories, nearly every family has boasted at least one nurse whose adventures inspired oft-repeated tales of humour, drama and romance.⁴
The occupation which captured so many imagininations and continues to demand devotion and dedication from its practitioners was recast in both structure and content in the late nineteenth century. In the industrial societies of Europe and North America the occupation came to be the means of subsistence for many women, usually strangers to the patient but formally trained and certified in the curative practices of scientific medicine. Over the course of the next one hundred years nurses became wage earners, the proletariat of medicine, who sold their labour to patients and executed the directives of doctors.5

Two powerful historical forces combined to forge this "new" occupation in late nineteenth-century Canada. The first was the incipient medical profession, consolidating its professional hegemony and requiring a skilled subservient workforce to provide the scientific therapy promised by "regular" medicine.6 In particular, the medical establishment in communities across the Dominion needed workers to staff the recently reorganized hospitals, now controlled by the medical profession and designed as laboratories where scientific treatments could be created and tested.7 Operating on the limited financial resources of charitable donations, government funding, and patient fees, these institutions established schools of nursing to provide cheap and skilled labour. Within this apprenticeship system of staffing and training, hospitals granted young women training and certification as graduate nurses
in return for two and later three years of service on the wards. Apprenticing nurses performed virtually all non-medical patient care, from cleaning supplies, to feeding patients, to assisting doctors, to comforting family. The entire range of patient services -- in the hospital of the 1980s performed by a host of subsidiary attendents -- were dispensed by student nurses, their few graduate nurse supervisors, and the small contingent of orderlies called in to assist with male patients. Upon graduation, the great majority of nurses turned to the private health care market to earn their living, providing home care for individual paying patients and their families.8

The creation of a corps of trained nurses was supported by a different but equally important social force of the late nineteenth-century, "first wave" feminists. This articulate generation of women pursued a strategy of establishing "separate and legitimate" spheres of endeavour through which women could gain social, political and economic equality. Prominent national feminists such as Lady Aberdeen served as benefactresses for nursing programs like the Victorian Order of Nurses (VON), while regional leaders such as Halifax's Dr. Agnes Dennis donated their organizational skills to Local Councils of Women, Red Cross Societies, and VON Boards alike.9 At the same time, nursing leaders connected their struggles for improvements in nurses' status with the fight for female enfranchisement, and support for feminist organizations.10 Like their counterparts in teaching, medicine, and law, nursing pioneers
recognized that without the support of the women's movement their hopes for equal status would be seriously handicapped.\footnote{11}

In striving to establish nursing as skilled, waged labour, the medical profession and feminist leaders were operating within a very different health care system than that of today. During the 1870-1940 era, patients and their families paid -- with cash, with produce, on instalment, or, occasionally through private insurance plans -- for medical and institutional services. If payment could not be arranged, patients had to convince health authorities or private practitioners that they were deserving of charitable attendance. However reimbursed, most medical care continued to be delivered in patients' homes in this period, but hospitals, once solely used to care for indigent and often incurable patients, were attracting increasing numbers of patients from all social classes, and clients in the modern hospital expected to be discharged in better, rather than worse, health.

Like doctors, most trained or "graduate" nurses worked for private patients who engaged nurses for days, weeks, or months \textit{either} to offer individual care in the patient's home, \textit{or} to provide supplementary attendance "specialing" in private or semi-private hospital rooms. A very small group of graduates with special training could get work with private or publicly-funded health organizations, or with large companies in industrial nursing.\footnote{12} As well, some positions were available to graduate nurses in hospitals,
and their schools of nursing, to organize and supervise the work of student staff. Rural hospitals employed graduate nurses only at a slightly earlier point in time than did large urban hospitals in which postings on floor duty performing direct patient care were rare and considered temporary. It was not until the 1940s that large staffs of graduate nurses were permanently hired by all hospitals to assume the responsibilities that today are associated with the job of nurse. And, it was not until the post-World War II years that ward aides, nursing assistants, dietitians, physiotherapists, pharmacists, and the many other health care workers who now regularly appear on hospital wards joined nurses as frequent visitors to the bedside. Rather, throughout the years 1870-1940 student nurses were assigned the numerous tasks involved in patient care and ward maintenance as they advanced up the hierarchy of hospital training.\(^{13}\) Only the daily encounters with the small staff of internes, and orderlies broke the rhythm of female patient care provided by apprenticing students and their graduate supervisors.

This apprenticeship system of hospital staffing, and of nursing education, was adopted by institutions across Canada in the 1872-1920 period, when the majority of hospital nursing schools were established. Hospitals were charged with simultaneously producing healthy patients and creating a skilled workforce of trained attendants. This they did, and the success of the apprenticeship system was integral to changes occurring within health services generally. Over time, greater numbers of private practitioners
utilized hospitals to perform the new medical procedures that institutional staffing and equipment permitted. By the end of the nineteenth century parallel developments in mental health led to the establishment of asylums in all provinces to cope with what seemed like growing numbers of Canadians with mental ailments. The increased popularity of institutional services did not, however, alter the economic structure of the "fee for service" model which characterized the private system, nor did the division of labour change. In hospital and home care alike, the growing repertoire of therapeutics which constituted patient care was differentiated into medical functions and nursing tasks: the principal division within the health care workforce was between doctors and nurses, men and women. The gender relations of patriarchy were reproduced by and reinforced in the medical division of labour. It was within the sex-segregated world of scientific medicine that five generations of Canadian nurses have practised their craft.

The concept of generation is useful to capture the specific sets of political and economic conditions which defined nurses' experiences in the health care system. Beginning with the first generation of trained nurses "born" with the modern hospital in the late nineteenth century, each twenty to twenty-five years the political-economy of Canadian health care conditions substantially changed, creating a new generation with a unique set of experiences and attitudes. As with biological generations, distinctions between one experiential generation and another are somewhat artificial.
Individuals do not always fall neatly into a single category, and generations co-exist. Still, the concept of a generation helps to identify chronologically the changes which have occurred within nursing over the past century. At the same time the concept facilitates the analysis of how generations intersected to mediate change. Within the apprenticeship training system, older nurses were responsible not only for teaching students the content of nursing work, but also for serving as positive role models of working women. As students graduated from hospital programs, the many nursing organizations served as vehicles through which experienced nurses could initiate new practitioners into the workforce. The occupation's self-conscious elite even sponsored the writing and publication of nursing histories designed to record for future generations the struggles and successes of previous generations. Unlike any other female-dominated occupation, the interaction between generations of nurses -- between the experiences of veterans and the expectations of novices -- has structured women's initiation into the job of caring and has influenced nurses' understanding of their occupational identity.

The first generation emerged in the late 1870s through to approximately 1900: graduates from the few schools of nursing which had formed at large hospitals under the directorship of women trained outside Canada. For example, the Dominion's first school of nursing was established in 1874 at St. Catharines' Mack's Hospital. Irish trained, Dr. Theophilus Mack had established a successful
practice on the Niagara peninsula. His hotel and sanatorium attracted Irish labourers working in often dangerous conditions on the Welland Canal as well as other travellers on the Great Lakes, who like the labourers lacked suitable accommodation for domestic health care. Mack also convinced the federal and provincial governments to build a marine hospital for the itinerant maritime labour force. In all these endeavours the entrepreneurial physician encountered "the prejudice held by many sick people against going into public hospitals" and concluded that the negative image of institutional care "could best be overcome by building up a profession of trained lay nurses." He arranged for the St. Catharines' General and Marine Hospital to engage two Nightingale nurses from England together with two young students recruited locally, and instructed his nursing staff "to faithfully carry out the physician's directions, and in the event of emergencies, to report any instance when the execution of his orders have been exceeded or omitted." While early schools such as Mack's successfully relied upon imported administrators to educate future Canadian nurses, other Canadian women were availing themselves of the many American training programs. Some such as Isabel Hampton Robb and Mary Adelaide Nutting remained in the United States to pursue prominent careers as nursing leaders. Others returned to administrative postings in Canada. Johns Hopkins School of Nursing graduate, Mary Agnes Snively, assumed the superintendency of Toronto General Hospital and became the driving force behind the
Canadian Nurses' Association (CNA). As Figure 1.1 shows, training schools were established in almost every major hospital across Canada by 1900.

**Figure 1.1**

Canadian Training Schools Established Prior to 1900

<table>
<thead>
<tr>
<th>City</th>
<th>School</th>
<th>Date Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Catharines</td>
<td>Mack's Training School</td>
<td>1874</td>
</tr>
<tr>
<td>Montreal</td>
<td>Montreal General</td>
<td>1875</td>
</tr>
<tr>
<td>Toronto</td>
<td>Toronto General</td>
<td>1881</td>
</tr>
<tr>
<td>Toronto</td>
<td>Sick Children's</td>
<td>1886</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>Winnipeg General</td>
<td>1887</td>
</tr>
<tr>
<td>Fredericton</td>
<td>Victoria Public</td>
<td>1887</td>
</tr>
<tr>
<td>Saint John, N.B.</td>
<td>St. John General</td>
<td>1887</td>
</tr>
<tr>
<td>London</td>
<td>Victoria</td>
<td>1883</td>
</tr>
<tr>
<td>Guelph</td>
<td>Guelph General</td>
<td>1885</td>
</tr>
<tr>
<td>Ottawa</td>
<td>Lady Stanley Institute</td>
<td>1890</td>
</tr>
<tr>
<td>Galt</td>
<td>Galt General</td>
<td>1890</td>
</tr>
<tr>
<td>Brockville</td>
<td>Brockville General</td>
<td>1890</td>
</tr>
<tr>
<td>Peterborough</td>
<td>Nicholls</td>
<td>1890</td>
</tr>
<tr>
<td>Halifax</td>
<td>Victoria General</td>
<td>1890</td>
</tr>
<tr>
<td>Charlottetown</td>
<td>Prince Edward Island</td>
<td>1890</td>
</tr>
<tr>
<td>Hamilton</td>
<td>Hamilton General</td>
<td>1890</td>
</tr>
<tr>
<td>Chatham</td>
<td>Chatham General</td>
<td>1891</td>
</tr>
<tr>
<td>Victoria</td>
<td>Royal Jubilee</td>
<td>1891</td>
</tr>
<tr>
<td>Toronto</td>
<td>St. Michael's, Sisters of St. Joseph</td>
<td>1892</td>
</tr>
<tr>
<td>Medicine Hat</td>
<td>Medicine Hat General</td>
<td>1894</td>
</tr>
<tr>
<td>Montreal</td>
<td>Royal Victoria</td>
<td>1894</td>
</tr>
<tr>
<td>Montreal</td>
<td>Homeopathic</td>
<td>1895</td>
</tr>
<tr>
<td>Calgary</td>
<td>Calgary General</td>
<td>1895</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>St. Boniface, Grey Nuns</td>
<td>1897</td>
</tr>
<tr>
<td>Guelph</td>
<td>Srs of St. Joseph of Hamilton</td>
<td>1899</td>
</tr>
</tbody>
</table>

Source: Gibbon and Mathewson, *Three Centuries of Canadian Nursing*

Reflecting the fact that the number of beds provided by institutions was still limited, relatively few students graduated from nineteenth-century nursing schools. Thus the first generation of Canadian practitioners was distinctive in terms of its small size, its strong
sense of vocation, and the complex web of interpersonal relations which developed among this pioneer generation and between nurses and feminists.

The second generation of trained nurses was a product of a significant change in scale as greater numbers of hospitals, large and small, instituted the student system of staffing in the first two decades of the twentieth century. Hospitals, asylums and public health programs, and with them their graduate nurse administrators, all secured significant places in a health care system which increasingly brought Canadians into contact with medical experts. The years 1900-1920 were formative as nursing organizations were established at the local, provincial and national levels. Through them nurses struggled to achieve legislative and organizational self-definition, and to provide social and occupational services for members. The official voice of the Canadian Nurses' Association, the Canadian Nurse, began publication in 1905. Overseas, Canadian nurses gained recognition for their contributions to the allied war effort, while two domestic emergencies, the 1917 Halifax Explosion and the 1918 Influenza Epidemic called nurses into action in equally heroic ways.¹⁹ Combat and emergency service enhanced the reputation of nursing, aiding recruitment into training programs and convincing many nurses of the social justice and necessity of female enfranchisement. Military nurses such as Winnipeg General Hospital's Margaret McGillvary returned to civilian life as hospital
supervisors, bringing self-confidence and discipline to their duties overseeing a new generation of graduates.

Throughout the 1920s and 1930s a third generation of Canadian nurses reaped the benefits of their predecessors, having won some formal recognition within the private market of the difference between trained and untrained attendants. By 1922 every provincial association had registration legislation established, empowering nursing organizations to define educational standards, administrate annual examinations for Registered Nurse (RN) licensing, and to operate employment services for hospital graduates who successfully qualified as RNs. As well, nursing leaders finally achieved what their American sisters had earned years before university affiliation.20 Offering a different model and implicit critique of apprenticeship training, programs at the universities of British Columbia and Toronto granted Bachelors in Science and Public Health respectively for those few women possessing university entrance education and tuition fees. Nursing educators hoped university affiliation would break nursing's dependency upon the needs of the hospital. Yet despite this critique of apprenticeship training, most nurses of the 1920s and 1930s received their education on the ward. They then worked as graduate or Registered nurses in the private market wherein they confronted an economic crisis beginning to undermine the traditional form of employment. At the same time the increased popularity of hospitals, both as venues for subsidized medical care and as sites for more advanced
medical procedures, created a pressing need for ever-larger nursing staffs. Hospitals responded by expanding their traditional student workforce, annually graduating nurses into a private market which was already unable to employ the available supply. Unemployment among graduate nurses was still further exacerbated by the Great Depression, leading to an exodus of nurses from the country and from active practice. The impact of nurses’ outmigration was keenly felt when the advent of World War II created new employment opportunities for nurses in military and institutional service. After two decades of an oversupply of nurses, Canadian hospitals and patients suddenly faced a nursing shortage which lasted well after the end of the war.

For the fourth generation of nurses graduating in the early 1940s work conditions were dramatically different. World War II and its aftermath saw dramatically improved health care funding which stabilized hospitals and transformed them into the primary employer of not only graduate nurses but also a host of subsidiary workers. Large numbers of graduate nurses laboured in large hospitals, not dissimilar to some factory conditions. They were paid by a single employer and became increasingly responsible to doctor and administrator rather than patient. The apprenticeship system of nursing training persisted, but the apprenticeship system of staffing did not. The rise of the welfare state signalled the final phase in the proletarianization of nurses. Between 1942 and 1966 private duty work all but disappeared, resembling as it did the many
artisanal crafts which in earlier decades had given way to factory production. Out of this transformed structure of nursing work came the first signs of new forms of collective action by nurses. Federal promotion of unionization during the war led to experimentation by nurses with collective bargaining, albeit within the traditional associational forms.23

Only in the fifth and current generation did Canadian nurses create new vehicles for demanding improved wages and working conditions.24 In each province, unions assumed responsibility for negotiating contracts with hospital boards, leaving the traditional associations to control licensing and education.25 Since the late 1960s the rise of nursing unionization, the advent of medicare, and the demise of the apprenticeship system of education -- most schools are organized by community colleges and universities, with only a few large hospitals retaining their own training programs -- have distinguished the current generation of nurses.26

The dramatic changes to nursing education and work influenced and were influenced by Canada's new era of socialized medicine developed during post-war reconstruction to address the problems which had plagued health services in the 1920s and 1930s. After two decades of chaos during which nurses bore more than their share of unemployment, displacement and disillusionment, the Second World War sparked both a reformulation of medical funding and a dramatic shortage of trained attendants, developments which gave
birth to the modern system of highly-technical, hospital-based
nursing practice.

Within the mythology of Canadian nursing the passing of this
earlier world of nursing services is not mourned. Nursing histories
speak with pride of the eradication of the exploitative
apprenticeship system, and of the elevated status nurses have
enjoyed with the shift to hospital employment of graduate staffs.
This standard interpretation credits the rapid development of new
medical technologies and therapies -- many of which nurses
inherited as doctors took on newer procedures -- as the primary
causal factor in the demise of the apprenticeship system of hospital
staffing. That is, as physicians and surgeons developed innovative
medical interventions, older, more established procedures were
assigned to nurses. Inexperienced student nurses could not be
expected to perform these difficult tasks. Thus, it is claimed, the
need for the more highly-skilled care intensified to the point where
large staffs of graduate nurses were responsible for providing
increasingly sophisticated nursing care. Students were left to
benefit from improved educational programs in which learning rather
than labour were emphasized. Contemporary critics confess that
although students still performed many essential personal-care and
ward-maintenance services, as did the large numbers of practical
nurses and orderlies now on staff, the "old days" of relying almost
exclusively on cheap student labour was gone.
For all its romantic value, this portrait of progress is flawed. Firstly it misrepresents and devalues the experiences of the women who worked as nurses in these earlier generations. Conventional nursing histories do herald organizational achievements, the work of "pioneers", the first graduates, professional and educational reformers, the noble public health nurses, and famous superintendents. But the daily world inhabited by nursing's majority, the "rank and file" of private duty and hospital nurses, is treated as a curious, if not contemptible relic of a bygone age. Missing from this approach is an analysis of either the therapeutic efficacy of the interwar nursing service, or its contributions to the developing Canadian health system. Equally conspicuous by its absence is the acknowledgement that, for all its problems, private employment was the preferred subsector of nursing work. Detailing the experiences of ordinary nurses discloses aspects of waged work which women themselves valued.

The second flaw in the traditional approach is its failure to address the social and economic dynamics of the transition to the modern health system. Positioning technological innovation at the centre of historical change has blinded nursing scholars to the political, financial and human conditions which influenced doctors, nurses and institutional facilities. The solutions to the interwar health care crisis were neither inevitable nor self-evident, and
choices made during these years continue to affect the Canadian health system.

To reclaim from obscurity the experiences, attitudes and actions of Canada's third generation of trained nurses, this thesis examines the structure and content of nurses' work, the workforce, and nursing organizations from 1920 to 1939. Two propositions are central to this study. The first asserts that the 1920s and 1930s were decades of crisis for Canadian nurses during which the preconditions were established for the rapid transformations of nurses' employment in the 1940s and 1950s. The crisis was national in scope and endemic to the health care system, and was therefore exacerbated rather than created by the depression of the 1930s. The forces of change included the labour market, the medical economy, scientific and technological developments -- and significantly -- the actions of nurses themselves. This leads to the second and related proposition of this thesis. The structure and content of nurses' work created a unique occupational identity, manifest through individual acts as well as the collective voices of nursing organizations. This identity served to define and defend nurses at the workplace and in society.

In order to investigate these propositions two issues must first be clarified. First, because the act of nursing is integral to maternal care, it is often conceptualized ahistorically. The very word "nurse" evokes the maternal caring we often assume to be
central to human existence; we have all been sick, and we have all been nursed to health. However, illness, healing and the role of nursing are defined differently according to time and place. This first chapter establishes the time line of health nursing services in the nation-state of Canada. Having established the broad historical framework, approaching nursing from a critical perspective raises a second issue. Which critical perspective is most appropriate? Nursing is many things at once. It is caring and curing, it is work but also a vocation, it is highly celebrated but not always valued. Chapter 2, "Nurses and Historians", introduces the problem of how nursing's history is to be interpreted and suggests the diverse body of secondary literature from which the historical investigation of nursing can benefit and to which it can contribute. As well, that chapter includes a methodological discussion regarding the kind of sources available to document nursing in interwar Canada.

Chapter 3 engages directly in that documentation, examining on a national level the composition of the nursing workforce, the occupation's economic crisis evident as early as 1920, and the differential impact of that crisis on the three subsectors of the occupation. Chapter 4 provides a detailed examination of nursing in Winnipeg. In the hospital's role as causal force in both the creation of, and the solution to, the economic crisis and in the features of private duty work which attracted nurses, that prairie capital epitomized the situation facing nurses in Canada's other regional centres. In Chapter 5 sources on Winnipeg are utilized to assess the
relationship between science and skill in apprenticeship training which determined both the content of nurses' work and the occupational identity of graduate practitioners. Chapter 6 analyses the organizational structure of nurses' associations and their collective efforts to resist the forces undermining the occupation of which nurses were so proud, and more positively to reformulate health services so as to ensure the value of caring. In the concluding chapter, the meaning of two decades of Canadian nursing is evaluated in terms of the history of nursing and the writing of nursing history.

Several features of nursing's history define the parameters of this study. First, by 1922 nursing organizations in all provinces had achieved legislative definition of the "Registered Nurse" (RN). While most graduate nurses chose to gain RN status, not all did. Nor did many interwar commentators distinguish between the two levels of status. Since all RNs were graduates, but not all graduates were RNs I have chosen to discuss here the broader category of graduate nurse.30

Secondly, the history of nursing in Quebec fits only partially the model presented in this thesis. In that province, church and state combined to create a system of social services significantly different from that developed elsewhere in Canada. The Quebec Public Charities Act of 1921 rearticulated the historic importance of religious social service work, and ensured the Catholic church's
continued dominance as provider of Quebec's institutional health services. As Marta Danylewycz's 1987 publication *Taking the Veil: An Alternative to Marriage, Motherhood, and Spinsterhood in Quebec, 1840-1920* revealed, women played a critical role in the administration of Catholic hospitals. In the mid-nineteenth century the number female orders began to increase, and the number of nuns continued to expand until the 1950s, nearly doubling between 1921 and 1941 alone. Female religious orders provided a pool of skilled administrators for Catholic hospitals, a fact which influenced dramatically the options and experiences of all Quebec nurses. On the one hand, administrative positions were reserved for nuns, and thus, relative to their peers elsewhere, lay women enjoyed limited occupational advancement up Quebec's health care hierarchy. On the other hand, those nuns who did receive administrative postings in Quebec hospitals were not subordinate to male medical superintendents and thus enjoyed relatively greater authority and autonomy than Protestant or lay nursing administrators.

For all these differences, important similarities between the histories of Quebec nurses and other Canadian nurses did exist. In the late nineteenth century hospitals in Quebec, as elsewhere in Canada, established schools of nursing in which lay women could apprentice. The apprenticeship system created a sex-specific workplace, and workforce, as well as working conditions characterized by long hours and physical labour. During the interwar years, French-speaking nurses did develop a separate organizational
forum, and publication, but both French and English-speaking Quebec nurses remained active within their provincial body and the national association.\textsuperscript{34} In addition, since World War II, Quebec nurses have unionized to confront workplace issues in a pattern similar to that of other Canadian nurses. Feminist researchers in Quebec are currently investigating the unique circumstances of nursing history in Quebec,\textsuperscript{35} and, until that research is more fully developed, the place of Quebec nursing history within the larger history of Canadian nursing remains unresolved. Therefore for the purposes of this thesis, Quebec nurses have been included where the historical pattern does not deviate significantly, with the proviso that future research will confirm the applicability of the broader conclusions.

Acknowledging the distinct pattern of Quebec nursing history is also important as a necessary reminder of the significant role played by religious organizations in the development of health services throughout Canada. The Catholic, Mennonite, Salvation Army, and United Churches, to name but a few, all engaged in the provision of Canadian hospital and medical services. 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.\textsuperscript{36} As well, even at "lay" hospitals nursing ceremony included a heavy dose of Christian ritual.\textsuperscript{37} However, religious influence upon social services in provinces other than Quebec remains an underdeveloped area of the historical scholarship.
Developing a critical perspective on religious health care structures is further inhibited by the limited availability of primary documentation. Primary source material from those privately administered institutions have less frequently been deposited in public archives, and are only now being made available to historians. Thus, a third qualification of this thesis acknowledges that much of the available evidence pertains to nurses who trained and worked at large, secular hospitals.

And finally, developing a periodization for nurses' experiences during the Second World War remains a unfinished task. Certainly military nursing can be conceptualized according to the chronology of the war itself. But for the domestic nursing service, the first few years of the war had many features in common with the pre-war years. Nursing shortages prompted by military activity did not alter the intense pace of work which had characterized nursing service during the depression. As well, the trend toward hospital employment continued unabated whereas the number of graduate nurses in private practice remained the same as it had been in 1930. After 1942, however, federal financing of hospitals and wartime legislation hoping to stabilize the economy through unionization signalled a new era for nursing. Whether the graduates of the classes of 1940, 1941 and 1942 best fit in the third or fourth generation, I have chosen to focus on experiences of the third generation up to the beginning of the war. Future research will address the precise chronology in greater detail. This thesis will
extend its analysis back from the turbulent war years into the crisis of the interwar decades to assess the structural and human forces establishing the preconditions for change.

In order to investigate the world of Canadian nursing, 1920-1939, a wide variety of primary sources was utilized. Given the national nature of the interwar economic crisis, the logical starting place for such a study was national source material such as the decennial Census of Canada, the Directory of Hospitals, Minutes of the Biennial Meetings of the Canadian Nurses' Association, the Canadian Nurse and George M. Weir's 1932 publication Survey of Nursing Education in Canada. While these provided much essential information it soon became apparent that they could not answer certain kinds of questions. For instance, the Censuses and the Weir reports contained important numerical information describing the size and composition of the Canadian nursing workforce, but did not facilitate an exploration of causal factors determining the characteristics of the national corps of nurses. Similarly, the Canadian Nurses' Association Minutes and monthly journal discussed problems faced by the ordinary nurse. Unfortunately, too often the voices of private duty nurses were drowned out in a chorus of concern over nursing education and over the needs to raise entrance standards and improve curriculum so as to gain professional recognition for the occupation.
In order to probe beyond the professional strategies of the national elite, and develop an explanatory model for the changes occurring within health care system, more local sources were essential. After surveying the available primary nursing sources in each region of Canada, Winnipeg was chosen as the focus of a case study of Canadian nurses. Manitoba's capital city was selected for several reasons. In many ways the development of its medical profession and health care institutions was typical of North American cities. The establishment during the 1870-1920 period of a variety of public and private, lay and religious hospitals, of a university medical school, and of hospital schools of nursing created an indigenous population of trained practitioners, many of whom made substantial contributions to the international health community. For instance, the oldest and largest health institution in Winnipeg, the Winnipeg General Hospital [WGH] produced two highly-respected nursing leaders, Isabel Maitland Stewart and Ethel Johns.42

The careers of Ethel Johns and Isabel Maitland Stewart provide a fascinating contrast to highlight Winnipeg's place in the national and international network of health systems. Both graduates of the Winnipeg General class of 1902, Johns and Stewart cut their organizational teeth on the newly formed WGH Alumnae Association (WGHAA). In 1907 managing editor Stewart, and editor Johns collaborated in the publication of the Alumnae's first Journal.
before leaving Winnipeg for further education at Columbia University Teacher College's Department of Nursing Education. Johns subsequently returned to Canada, while Stewart stayed on at Columbia first as Assistant Professor, and then, succeeding pioneer educator Adelaide Nutting, as Professor of Columbia's nursing program. In addition to her many American achievements as teacher, author and administrator, Stewart remained committed to Canadian nursing at both the national and local level. Many CNA biennial meetings were opened with Stewart's greetings on behalf of the American Nurses Association, while the WGHAA Archives inherited many of Stewart's personal mementoes. Johns' career took a slightly different path, one which brought the two classmates together as friends, and then pulled them apart. Johns' career as Nursing Superintendent began at Fort William, then continued at Winnipeg's Children's Hospital until 1919 when her support for the General Strike drove her to the west coast. Johns quickly found new employment as Superintendent of Nursing at the Vancouver General Hospital, and immediately went on to negotiate a full-time position as head of the newly established University of British Columbia School of Nursing. Her early editorial skills served her well in the following years. In 1925 the Rockefeller Foundation commissioned her to study, among other things, the training of black nurses in the United States. Johns' report, shelved by the Foundation because of its unequivocal condemnation of the nursing education black women received, led to a falling out with the now-celebrated American
nursing educator Stewart.\textsuperscript{46} Even after Johns completed her Rockefeller postings in Hungary and Rumania, and returned to Canada as editor of the \textit{Canadian Nurse} from 1933 to 1944, and even though she continued to visit the Stewart family in Vancouver, her friendship with Stewart was never repaired.\textsuperscript{47} Johns' literary career continued after her retirement, when she was requested to write the history of the WGH School of Nursing for the Golden Jubilee of the Alumnae Association. Stewart's publications continued to be reprinted, with each new edition serving as a cornerstone of American nursing programs.\textsuperscript{48} While their personal differences were never resolved, their career paths led them both back to the Winnipeg General Hospital where mementoes of their professional lives remain the centrepieces of the Alumnae Archival collection.

The careers of individuals such as Johns and Stewart maintained Winnipeg's ties with the international health care community. In addition, the city's health care system reflected some uniquely Canadian features of health services. It has traditionally served as a regional centre for health services for the Prairie provinces and the Canadian northwest, and its geographic centrality determined its choice as home of the Canadian Nurses' Association head office for most of the interwar years. Winnipeg's class, ethnic and race relations, and diverse industrial and service economy paralleled those of Toronto or Montreal, but the smaller size of the Prairie metropolis made studying its nursing population more manageable. Maritime economic underdevelopment in the post-
World War I decades and the absence of a medical school in British Columbia made Halifax and Vancouver exceptional rather than exemplary, and therefore less useful case studies. And finally, Winnipeg is my home. Since sources for women's history generally, and nursing history specifically must be tracked down from a variety of libraries and archives, associational offices, personal collections and individual memories, my familiarity with Winnipeg and the people in its communities facilitated the difficult task of locating or gaining access to primary source material.49

Some conventional sources were available in Manitoba repositories. Like many provincial archives, the Public Archives of Manitoba has begun only recently to acquire medical sources but while collections such as that for the Winnipeg General Hospital included Annual Reports, and House Committee Minutes contained valuable nursing data, it did not include records of the training school or nursing staff.50 Other published local sources such as Henderson's Directory permitted a headcount of Winnipeg's nursing workforce to verify numbers calculated for the city by the Census51 Private libraries and archives boasted larger collections, though inferior storage facilities. The Manitoba Association of Registered Nurses (MARN) preserved their Board of Directors Minutes and Central Registry Committee Annual Reports, and the Winnipeg General Hospital School of Nursing Alumnae Association Archives (WGHAA) included in its holdings backcopies of its own publication the Alumnae Journal.
Private repositories also housed documents which were less obvious choices of source material. The WGHAA Archives' collection of yearbooks, created annually by the graduating class of student nurses, contained basic information not listed in any other WGH source -- the names and hometowns of each graduate. The "Blue and White" series also included poetry, prose and jokes written by student nurses about their three years of hospital apprenticeship which together offered very different insights into the life and work of the hospital than that of annual reports. Manuscript evidence, such as student notebooks and lecture notes, donated to private collections by nurses and their families not only provided another type of source, but suggested the existence of similar documents possibly preserved by individuals themselves.

Many such documents were located as part of the process whereby retired nurses of the interwar years were interviewed about their recollections and experiences. More than twenty members of the third generation of Canadian nurses, women who trained and worked during the 1920s and 1930s, participated in tape recorded interviews. Oral testimony utilized in this study comes predominantly from a set of fifteen interviews with Winnipeg General Hospital School of Nursing graduates conducted by the author between June 1987 and August 1988. Appendix A provides the names and biographical information of the fifteen WGH Alumnae included in the project. To identify participants, a list of names and
addresses of all WGH graduates of the 1920-1940 years was supplied by the WGH Alumnae Association. This large pool of potential participants was narrowed by several factors. First, the graduates had to be alive and healthy enough to participate. Secondly, alumnae members had to be living or around Vancouver or Winnipeg. Thirdly, they had to have worked as nurses in the paid labour force after graduation, even if only for a short time. And finally, the women themselves had to be willing to have their experiences tape recorded and made available in archival repositories.\(^{53}\) Even with these conditions, the number of possible participants was large, and, thus, two further factors informed the selection process. Informal conversations with Alumnae Association “class reps” identified those members who had the longest work record, most variety, and least amount of public health experience. And, given the relatively smaller pool of older nurses, where possible graduates of earlier years were preferred over graduates of the late 1930s.

The following group profile describes the collective characteristics of the fifteen WGH graduates interviewed. All were born between 1896 and 1912. All but one were Canadian born, and all but one Protestant. Anne Ross, a Russian Jew, was ten years old when her family emigrated from the Ukraine in 1921. One interview participant completed only grade 10, 10 finished grade 11, 4 completed grade 12, and three attended university for one or two years prior to entering training school. No graduates of the post-
1935 classes were interviewed. Nine of the fifteen completed their nursing education in the 1920s, with the following distribution by year of graduation: 1921 (1), 1922 (1), 1924 (2), 1926 (1), 1928 (3), 1929 (1), 1930 (2), 1931 (2), 1934 (1), and 1935 (1). Each participant apprenticed at WGH for three years, and as a group their training school experiences spanned the years 1918-1935.

The work experiences of the group were more diverse than their sociological or educational characteristics. Of the fifteen participants, six remained single and through nursing work supported themselves until their retirements in the 1970s. Nine of the interview participants married. Of those nine, two left the paid workforce permanently after marriage. Mary Duncan retired after four years of paid employment, and Ingibjorg Cross retired after twenty-six years as a nurse. The seven others returned to paid nursing work after marriage for a variety of reasons, and after a wide range of years outside the paid labour force. Myrtle Crawford, Anne Ross, Olive Irwin, and Florence Paulson all re-entered the paid workforce to contribute to family incomes. Josephine Mann left nursing in 1939, but returned to it when her husband’s disability shifted financial responsibility back onto Josephine’s shoulders. Vera Chapman and Violet McMillan, best friends in training school, both learned the value of nursing credentials when their husbands died. Chapman resigned from paid work when she married in 1935. Five weeks later, her husband suddenly died, and Chapman returned to nursing until her second marriage in 1945 prompted her to leave
nursing permanently. McMillan also married and left nursing in 1935. She too returned to nursing upon the death of her husband in 1959, but for McMillan that meant re-entering paid work at the age of 52, twenty-four years after her last nursing job. This brief summary of the career patterns of the fifteen-person interview group highlights the lifelong significance of nursing to many of the women, regardless of their marital choices. The fact that many women left and reentered the paid workforce in no way undermines the credibility of their recollections regarding the period under study. Figure 1.2 lists the paid work experience of the interview group during the 1920s and 1930s.

Figure 1.2
Pre-1940 Work Experience of WGH Interview Sample

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Graduation</th>
<th>Last year of Work Before 1940</th>
<th>Total Years Before 1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irwin</td>
<td>1921</td>
<td>1925</td>
<td>3</td>
</tr>
<tr>
<td>Paulson</td>
<td>1922</td>
<td>1927</td>
<td>5</td>
</tr>
<tr>
<td>Cross</td>
<td>1924</td>
<td>1940</td>
<td>16</td>
</tr>
<tr>
<td>Parker</td>
<td>1924</td>
<td>1940</td>
<td>16</td>
</tr>
<tr>
<td>Duncan</td>
<td>1926</td>
<td>1930</td>
<td>4</td>
</tr>
<tr>
<td>Mann</td>
<td>1928</td>
<td>1939</td>
<td>11</td>
</tr>
<tr>
<td>Shepherd</td>
<td>1928</td>
<td>1940</td>
<td>12</td>
</tr>
<tr>
<td>Smith</td>
<td>1928</td>
<td>1940</td>
<td>12</td>
</tr>
<tr>
<td>Cameron</td>
<td>1929</td>
<td>1940</td>
<td>11</td>
</tr>
<tr>
<td>Chapman</td>
<td>1930</td>
<td>1949</td>
<td>10</td>
</tr>
<tr>
<td>McMillan</td>
<td>1930</td>
<td>1935</td>
<td>5</td>
</tr>
<tr>
<td>Crawford</td>
<td>1931</td>
<td>1933</td>
<td>2</td>
</tr>
<tr>
<td>Lytle</td>
<td>1931</td>
<td>1940</td>
<td>9</td>
</tr>
<tr>
<td>Ross</td>
<td>1934</td>
<td>@1937</td>
<td>@3</td>
</tr>
<tr>
<td>Seeman</td>
<td>1935</td>
<td>1940</td>
<td>5</td>
</tr>
</tbody>
</table>

Total 124

Source: "Nurses and Their Work: An Oral History of Winnipeg Nursing, 1919-1939"
During the decades discussed in this thesis the interview group's collective, pre-1940 work experience averaged eight years, three and one-quarter months. The primary data generated by this interview project was complimented by interviews conducted with graduates of other Canadian training hospitals during the 1920s and 1930s. Tape recorded interviews with Bess Purdy and Wilma Nicoll (Brandon General Hospital), Harriet Pentland (Vancouver General Hospital), Cali Dunsmaur (Vancouver General Hospital), Jessie Law (Vancouver General Hospital) and Irene McGilvary (Winnipeg Children's Hospital) were conducted in a similar method as those of the WGH collection and were used to confirm and enhance the oral testimony of the WGH alumnae.

The interviews, conducted in the participants homes, were loosely structured around a set of prepared questions and focused mainly upon the nurses' apprenticeship and work during the interwar years. The fact that I am not a nurse produced some negative responses from potential participants, but in general my "lay" status served as a positive feature of our interaction since participants felt confident in explaining in great detail features of their occupation which an outsider like myself would not know. The subjectivity which necessarily characterizes the relationship between interviewee and interviewer was manifest in the participant's responses to certain questions, but also in my own reticence to broach subjects of a personal or potentially-
embarrassing nature. The conditions of the interview, that it would be tape-recorded, that copies would be available for access by other researchers, that the area of inquiry was their working lives, and that the participants had never met me before, created a formality of interaction which may have limited the breadth of discussion, but also may have ensured the confidence of the participant. As much as possible, the questions were posed so as to elicit detailed descriptions and so as not to predetermine the answer.

The participants themselves were very conscious that many events "happened a long time ago," and some differences did emerge in their descriptions of the same events. As well, some adventures of other nurses were obviously imbedded in the oral legacy of the WGH Alumnae Association as allusions to some stories were made by several participants. Contradictions and differences in the oral testimony were checked with accounts documented in printed documents; and in general the interview data was utilized with sensitivity to the influence of time on memory. These limitations notwithstanding, the collection of interviews are remarkable for the commonality of experience and attitude they represent.

Contact with women who lived the history I am writing produced a final benefit. They kept material sources. Many had scrapbooks, yearbooks, pins and other memorabilia ready to show me when I arrived at their homes; others gladly located their personal
collection upon request. Mementoes such as Myrtle Crawford's notebooks of nursing techniques, one created by Crawford and the other by her older sister who died of tuberculosis early in her nursing career, proved invaluable.\textsuperscript{58} Most important, however, was Mary Shepherd's collection which contained letters and information received from her alma mater, the Winnipeg General, as well as samples of the staff records kept by Winnipeg's Municipal Hospital. The latter evidence documented her claims that most staff records had been burned due to lack of storage space.\textsuperscript{59}

The process of researching nursing history in Winnipeg confirmed the feminist supposition that women's history demands an alternate methodology than that employed by traditional historical research.\textsuperscript{60} The creation and preservation of historical documents were influenced by the same forces creating and preserving unequal social relations. Much documentation did not include information on women. Those sources which were created by and about women often did not survive to the present day. By locating, and creating, new sources of primary documentation, and by asking new questions of conventional historical sources, this thesis addresses several critical issues in the historical literature on Canadian health, work and women.
Notes

1 Monica E. Baly, *Florence Nightingale and the Nursing Legacy* (Croom Helm: London, 1986) is the most recent in a long line of Nightingale biographies. Of this literature, F. B. Smith's *Florence Nightingale: Reputation and Power* (London: Croom Helm, 1982) is, by far the most critical. Smith describes Nightingale as a manipulative and often deceitful woman whose reputation within nursing was only an accidental by-product of her real interest in army sanitation reform -- a dramatically different portrait than the traditional image of the "lady with the lamp". Within nursing history most biographical studies present more positive images of their subjects than does Smith. See for example, Marion Royce's *Eunice Dyke: Health Care Pioneer* (Toronto: Dundurn Press, 1983).

2 See Barbara Melosh, "Doctors, Patients, and 'Big Nurse': Work and Gender in the Postwar Hospital" in E. C. Lagemann ed., *Nursing History: New Perspectives, New Possibilities* (Philadelphia: Temple University Press, 1984). In her study of Canada's significant contribution to this genre of literature, the Harlequin Romance novel, Jensen claims that "in Harlequins published ten or fifteen years ago, most heroines were high-school graduates: about a third of them had post-high school, non-university education like nurses' training or secretarial school.... Nurses, predominating in the 1950s and early 1960s were replaced by secretaries in the 1970s and the secretaries have, in turn, been supplanted by a more diverse group of heroines in the 1980s." See Margaret Ann Jensen, *Love's Sweet Return: The Harlequin Story* (Toronto: Women's Educational Press, 1984), p. 87.

3 Vancouver's recently demolished Georgia Medical-Dental building supported sculptures of four nurses on each upper corner. Only the nurse statues were saved before the building's destruction. Art historian Letia Richardson has also pointed out to me that Vancouver's New Romantic painter Angela Grossman has recently begun using nursing imagery in her work. See also Anne Hudson Jones, ed., *Images of Nurses: Perspectives from History, Art, and Literature* (Philadelphia: University of Pennsylvania Press, 1988) for further articles on American nursing imagery.
This fact has been driven home to me by the frequency with which discussions of my thesis work have provoked stories of family members who were/are nurses.

For an overview of this process as it occurred within American nursing see, Susan Reverby, *Ordered to Care: The Crisis of American Nursing 1850-1945* (Cambridge: Cambridge University Press, 1987), especially chs. 9 and 10; and David Wagner, "The Proletarianization of Nursing in the United States, 1932-1946," *International Journal of Health Services*, 10, no. 2, (1980): pp. 271-290. For an analysis of the proletarianization of British hospital nurses see, Paul Bellaby and Patrick Oribabor, "Determinants of the Occupational Strategies Adopted by British Hospital Nurses," *International Journal of Health Services*, 10, no. 2 (1980): pp 291-309. Defining the relation of white collar workers to the modern proletariat has provoked much academic debate. Have occupations such as clerical work and teaching been proletarianized? Have those workers experienced the objective conditions and exhibited the subjective characteristics of a true proletariat? Some contributors to this discussion have stressed the declining wages and standard of living, changes in the labour process, and the working-class consciousness of white collar workers which define them as part of the proletariat. For example, in his study of Ontario teachers since the 1930s Filson reviewed the major theoretical positions on proletarianization in order to assess the changing class relations of various sub-groups of teachers. See Glen Filson, "Ontario Teachers' Deprofessionalization and Proletarianization," *Comparative Education Review*, 32, no. 3 (1988): pp 298-317. However, Graham Lowe has critiqued this approach for conflating proletarianization with feminization and has argued that the fact that workers experienced certain changes in their occupational status did not necessarily determine "his or her location in the class structure - in particular, under what conditions this probably will be working class." (p. 165). Further studies such as Lowe's are needed to determine whether the concept of proletarianization is large enough to encompass gender and class stratification, or whether Lowe's suggestion that "perhaps it would be heuristically prudent to wipe the theoretical slate clean of the terminological baggage of proletarianization" will prove correct. See Graham Lowe, *The Administrative Revolution: The Feminization*
of Clerical Work (Toronto: University of Toronto Press, 1987), pp. 64-165. For the purpose of this thesis, the term proletarianization is used to describe the conditions of a centralized workplace, rationalization of the work process, the intensification of the pace of work, and the rigid, hierarchical division of labour which accompany "assembly-line" and factory production...and which came to dominate nursing work in post-World War II Canada. This corresponds with the use of the term proletarianization in the work of Reverby, Wagner, and Bellaby and Oribabor. For the 1932-1946 period in the United States, Wagner writes: "[The proletarianization process] included the forcible expulsion of the peasantry from the land, the decline of the handicraft production and artisanal skills, and the rise of factory production...The process of creating a labor force in nursing was analogous to driving the peasantry off the land in 18th and 19th Century England to accept factory work." (pp 271 & 283).


7 The relationship between the general hospital and Canadian medical profession has only recently attracted scholarly attention. For example, the work of Howell on Maritime institutions suggests that hospitals provided regular medicine with an institutional setting to which competitors did not have access. It is also possible that the involvement of the medical professions in local hospitals reinforced the connection between medical men and the social elites running benevolent enterprises, thereby affirming the elite status of doctors vis à vis competitors. No study such as that by Morris J. Vogel, The Invention of the Modern Hospital: Boston 1870-1930 (Chicago: University of Chicago Press, 1980) or Charles Rosenberg, The Care of Strangers: The Rise of America's Hospital System (New
York: Basic Books, Inc, 1987) has been completed for the Canadian setting.

8 McPherson, "Nurses and Nursing in Early Twentieth-Century Halifax"; Jo Anne Whittaker, "'Dogs and Seals are Trained, Nurses Are Educated. Aren't They?' Nursing Education in Canada, 1874-1930" (B.A. essay, University of Victoria, 1984), and "'Professionalization and Gender: The Case of the Registered Nurses Association of British Columbia" presented to the Fifth BC Studies Conference, Simon Fraser University, November 4-5, 1988.


10 For example, in April 1917 the Graduate Nurses' Association of Nova Scotia unanimously approved a resolution to "approve of the advisability of granting the franchise to women of the Province of Nova Scotia. Knowing that this is a work in which women and men, whether organized for suffrage or the moral and social welfare of the people are interested, we decided not to dissipate our energies trying to form new societies, but to work as far as possible through existing nursing organizations and other organizations of women and men favourable to the cause and that this committee do earnestly strive to bring about the cause of suffrage by working along the line of political education." Canadian Nurse, 13, no. 4 (April 1917): pp. 210-11.


13 See Whittaker, "Dogs and Seals are Trained, Nurses Are Educated. Aren't They?" for a critique of the term "training".


17 Ibid.


20 In 1899 the Teachers College of Columbia University became the first American post-secondary institution to grant university degrees to graduate nurses. Elizabeth Jamieson and Mary Sewall, *Trends in Nursing History: Their Relationship to World Events* (Philadelphia: W.B. Saunders Company, 1944), pp. 476-79.

21 Anne Crichton has termed this post-war transition "The Shift from Entrepreneurial to Political Power in the Canadian Health System", *Social Science and Medicine*, 10, pp. 59-66.

22 Joanne Whittaker alerted me to the persistence of the apprenticeship model within nursing education. The possibility that post-war nursing students did more unskilled domestic work than their pre-war counterparts is an interesting question for further research.


A sixth generation of Canadian nurses appears to be in gestation and, when born, faces the prospect of a dismantled welfare state.

Retired nurses interviewed for this thesis recalled clearly the 1940s during which many functions, previously performed by doctors, were assumed by nurses. For example, Beryl Seeman described the ambivalence of her medical colleagues when nurses started taking blood pressures. Beryl Seeman, interview by author, Tape recording, 8 July, 1987. Myrtle Crawford described her experiences in the late 1940s "when things got busier" and nurses, rather than internes, took over the task of starting intravenous lines. Myrtle Crawford, interview by author, 5 August, 1988.


Charles Rosenberg addresses the various historical approaches to the study of nursing's past in "Clio and Caring: An Agenda for American Historians and Nursing," Nursing Research 36, no. 1 (January/February 1987).

Reflecting the difference between the popular descriptive term "graduate" and the formal title of licensed "Registered" practitioners, only the latter term is capitalized throughout the text.


Marta Danylsewycz, Taking the Veil: An Alternative to Marriage, Motherhood, and Spinsterness in Quebec, 1840-1920 (Toronto: McClelland and Stewart, 1987)

The Montreal General Hospital established its training school in 1875, while the first program for French lay women was initiated in

34 Relations among nursing organizations are discussed in Chapter 6.


36 For example, Elizabeth Medeiros' initial research into nursing at two Toronto Catholic hospitals run by the Sister's of St. Joseph, St. Michael's Hospital and St. Joseph's, suggests that nuns who undertook nursing training were offered the most prestigious administrative postings, while graduate nurses who became nuns were placed as ward heads. Lay graduates of the two programs rarely earned hospital appointments. As well, nun-administrators of these Catholic hospitals used their religious communities and connections to develop an extensive network and mutual support system. Elizabeth Medeiros, "Catholic Nursing in Toronto - 1920s-1940s", unpublished paper, York University, 1990.

37 Christian prayers and hymns were part of the daily morning ritual and annual graduation exercises of large lay hospitals such as the Winnipeg General, Vancouver General and Halifax's Victoria General. All nurses were expected to attend, regardless of their personal religious beliefs. Anne Ross, interview by author, Tape recording, Winnipeg, Manitoba, 4 August 1988.

38 Ruth Roach Pierson asserts that for women workers during World War II the year 1942 was critical. Within the first two years of the war the surplus of unemployed workers had been reintegrated into domestic and military employment and by 1942 the federal government was looking to the "large labour reserve" of women. That year the National Selective Service was established with Mrs. Rex (Fraudina) Eaton appointed to head the Women's Division and intensify the recruitment of women into the Canadian war effort. Ruth Roach Pierson, "They're Still Women After All". *The Second World War and Canadian Womanhood* (Toronto: McClelland and
Stewart, 1986) pp. 22-24. McIntrye links changes in nurses professional status to the changes wrought by the Second World War, arguing that the "national registration of inactive and practising nurses, in March 1943" was critical in focusing professional dissatisfaction. Linda B. McIntrye, "Towards a Redefinition of Status: Professionalism in Canadian Nursing, 1939-45" (M.A. thesis, University of Western Ontario, 1984), p. 117.

39 Daigle's research on the unionization of nurses in Montreal follows a similar chronology, and places the wartime changes in the structure and content of nurses' work as critical factors in the emergence of post-war union activity. Daigle, "L'émergence et l'évolution de L'alliance des infirmières de Montréal: 1946-1966".


41 See Chapter 6 for a discussion of organizational structures and activities.

42 Stewart served as Professor in the Department of Nursing Education Teachers College, Columbia University, New York, the key post-graduate training program for nurses in North America. She was the author of one of the first histories of nursing A Short History of Nursing from the Earliest Times to the Present Day. Johns held several hospital positions as Superintendent of Nursing before being recruited by the Rockefeller Foundation to undertake studies of American nursing, including the controversial "A Study of the Present Status of the Negro Woman in Nursing, 1925" (Unpublished report, Rockefeller Foundation Archives). For a discussion of Johns' forty-three-page manuscript see, Darlene Clark Hine, "The Ethel Johns Report: Black Women in the Nursing Profession, 1925," Journal of Negro History, 67 (Fall 1982): pp. 212-228, and Black Women in White: Racial Conflict and Cooperation in the Nursing Profession 1890-1950 (Bloomington: Indian University Press, 1989).

43 See Margaret M. Street, Watch-fires on the Mountains: The Life and Writings of Ethel Johns (Toronto: University of Toronto Press,
1973) for an excellent biography of Johns, including some facets of Johns' and Stewart's relationship.

44 See for example CNA, Minutes, 1930.

45 Street, Watch-fires on the Mountains, especially chapters 10, 12 and 13.


47 Street's biography of Johns, Watchfires on the Mountain, makes only oblique reference to the disagreement between Johns and Stewart, but Joanne Whittaker has argued for a more substantial conflict. Johns' history of the WGHAA mentioned her illustrious classmate only a few times, and never acknowledged Stewart's many accomplishments or positions. See Ethel Johns, The Winnipeg General Hospital School of Nursing 1887-1953, (Winnipeg; 1953), pp. 32-33, p. 45.


49 For example, through a Province of Manitoba Oral History Grant, the WGH Nurses Alumnae Association and myself were funded to interview retired nurses of the WGH School. The success of the project "Nurses and Their Work: Oral Histories of Nursing in Winnipeg, 1920-1940" depended upon the network of friendships among the association members, as well as my own personal contacts in Winnipeg and surrounding communities. An interesting example of this is one interview subject whom I was warned might not agree to be interviewed since she had not been active in her
Alumnae Association, but who was an enthusiastic participant once she realized my father had taught her children.

50 F. Eaton's "Report of the Advisory Committee on Labour Conditions in Hospital" confirmed that this was not a problem specific to Winnipeg. For instance, Eaton wrote "In some hospitals, particularly those with training schools, exact records of illnesses of the staff are kept but all hospitals do not keep such records." p.18. E. MacPherson Dickson's "Report on the Survey of the Field of Nurse Training" (RNAO 1924) indicated that this problem had existed for some time. She stated "very few of the hospitals keep any kind of records of the students' work or experience beyond the date of admission to the training school and time lost through illness, or other causes during the period of training. The importance of the keeping of accurate records can hardly be over-estimated. I find that some of the graduates of our schools have been seriously handicapped by their inability to procure from their training schools information in regard to their training both theoretical and practical." p. 9. For a discussion of difficulties faced by archivists in their efforts to collect and preserve hospital records see Barbara Lazenby Craig, "The Canadian Hospital in History and Archives," Archivaria, 21, (Winter 1985-1986): pp. 52-67.

51 Henderson's Directory, 1929-1933.

52 "Nurses and Their Work: An Oral History of Winnipeg Nursing, 1919-1939," Provincial Archives of Manitoba. All interviews for this project were conducted by Kathryn McPherson.

53 This was one of the conditions of the Province of Manitoba Ministry of Culture, Heritage and Recreation Oral History Grants Program.

54 McMillan's age and lengthy absense from active duty made it difficult for her to find work, and, when she did secure a position at the WGH's Woman's Pavillon, she found the world of nursing had changed dramatically. With the help of her co-workers McMillan was informally retrained on the job. Violet McMillan, interview by author, Tape recording, Winnipeg, Manitoba 23 June 1987.

56 See for example, Mary Shepherd, interview by author, Tape Recording, 18 June 1987; and Helen Smith, interview by author, Tape recording, Winnipeg, Manitoba, 3 August 1988.

57 Selected source material from other centres is also utilized when available. Surveys and use of sources from holdings in Vancouver, Halifax, Toronto, and Montreal as well as interviews with nurses from across Canada collected as the survey of source material was being undertaken are incorporated where relevant.

58 See Chapter 5 for a discussion of sources on nursing technique.

59 Mary Shepherd, Tape recording.

Chapter 2

Placing Nursing History in History

The popularity of nursing as both cultural image and occupational choice has not been matched by scholarly interest. Nurses themselves, a highly articulate and self-conscious group, have written and published volumes celebrating the personalities, organizations and events which influenced their occupation over time, but by and large these studies have remained isolated from academic literature. Only recently has a critical body of scholarship emerged to place nurses in the broader historical context. Inspired by the dynamic dialogue among social, women’s, labour and medical history and informed by the inter-disciplinary approach influencing much historical research, the “new nursing history” has re-examined the working lives of nurses in a variety of geographical locations and chronological periods. Despite the wide range of thematic, theoretical and methodological approaches, two specific common features of this critical scholarship warrant special mention. Borrowing from the canons of social history to view the past “from the bottom up”, researchers have moved from studies of the articulate elites to investigations of ordinary nurses. In doing so a second powerful influence, coming from both women’s and labour history, has instructed historians to consider not only the patriarchal and/or capitalist structures circumscribing nurses’ lives but also the ways that nurses resisted these oppressive forces. The
impact of ordinary people on their own history has been coined "human agency".

The concept of agency has emerged as a common theme for labour historians convinced by E.P. Thompson's assertion that "the working class...was present at its own making" and for feminist historians conscious that women have not simply been passive victims of patriarchal domination. In her 1985 collection *Disorderly Conduct: Visions of Gender in Victorian America* American scholar Carroll Smith-Rosenberg rejected the idea that, lacking power, "women were only actors in a male play." Speaking for all women's historians Smith-Rosenberg declared:

We see history as an ongoing struggle between women and men actors for control of the script, a struggle that ultimately transforms the play, the players -- even the theater itself. But if we reject the view of women as passive victims, we face the need to identify the sources of power women used to act within a world determined to limit their power, to ignore their talents, to belittle or condemn their actions.

Informed by this historical tradition, this thesis is premised on the principle that a dialectical relationship exists between structural imperatives and human agency, and therefore that nurses themselves constitute a historical force. To investigate the world in which Canadian nurses lived and worked, three bodies of historiographical literature -- social history of medicine, Canadian nursing history,
and the socio-historical literature on women and work -- have been consulted.

In 1988 Canadian historian Colin Howell applauded his peers writing the social history of medicine for getting "back to the bedside" where "questions of class, power, ideology and social development" could be examined in all their complexity. The bedside attendance Dr. Howell prescribed for the "new generation of professional historians" was the logical corollary of the maxims of social history to "do history from the bottom up" and from labour to understand the "working class experience", "on the job" in both "class and community". However, Howell failed to mention that, ironically enough, for all the omnipresence of doctors in medical historiography, the visitor to the historical bedside might well have to wait some time to meet most patients' attending physician. Most times of the day or night, at home or in hospital, the person most likely to be in immediate contact with illness would be a woman, and by the twentieth century that woman would likely be a trained nurse. If historians are to act upon Howell's valuable advice to consider the social relations of health services then gender, and race as well, must join class as forces influencing interactions between doctors, nurses and patients.

To date Canadian social history of medicine has found integrating nursing issues a difficult task. Three collections of Canadian scholarship, Medicine in Canadian Society: Historical
Perspectives edited by, then Hannah Professor at Queen's University, S.E.D. Shortt; a volume published in 1984 by the Hannah Institute for the History of Medicine and edited by Hannah Professor at McMaster University Charles G. Roland, Health, Disease and Medicine: Essays in Canadian History; and the 1988 collection Essays in the History of Canadian Medicine edited by Wendy Mitchinson and Janice Dickin McGinnis contained a wide range, thematically and chronologically, of articles, yet not one contribution was dedicated to nurses or nursing. The Canadian Society for the History of Medicine demonstrated a similar difficulty attracting and inspiring submissions to the Canadian Bulletin of Medical History (CBHM) which included discussions on doctors' assistants at the bedside.

Margaret Andrew's 1979 doctoral dissertation, "Medical Services in Vancouver 1886-1920: A Study in the Interplay of Attitudes, Medical Knowledge, and Administrative Structures", examining the emergence of modern medical system on Canada's west coast, did refer briefly to the work of nurses in the Vancouver General Hospital (VGH) and during the city's influenza epidemic. Her assessment that, for example, the VGH training school "served patients only indirectly, and was in fact established primarily as a means of keeping hospital operating costs low" intimated an important avenue of further research on the political economy of the hospital. In a similar fashion, David Gagan's 1989 publication "For 'Patients of Moderate Means': The Transformation of Ontario's Public Hospitals 1880-1950" credited nursing and administrative reform as one of
several key factors causing the "radical transformation" of the general public hospital, but, as of yet, Gagan has not developed that particular theme. As the work of Gagan, and Andrews suggested, in spite of the dearth of material directly integrating nurses in the health care system, several points of intersection between medical and nursing history promise mutual benefit to the two sub-fields.

Most obvious is the history of the hospital wherein nurses learned their trade and supplied the majority of patient care. Conventional institutional histories traced the birth and growth of hospitals, assuming the humanitarian motives of founders, the inevitability of institutional success and the positive correlation among hospitals, medical science and improved community health. Challenging this conventional wisdom are authors such as historian F.B. Smith and sociologist Thomas McKeown who have questioned the assumed causal impact of medicine on "The People's Health". Other researchers have pointed to the political and economic factors, rather than simple therapeutic efficacy, effecting the social role of health institutions. British historian Brian Abel-Smith's pathbreaking 1964 study The Hospitals 1800-1948: A Study in Social Administration in England and Wales has been joined over the years by works such as Charles Rosenberg's The Care of Strangers: The Rise of America's Hospital System in placing the development of institutional services within the context of broader historical change. While some debate exists regarding the precise interplay of social, political and economic factors leading to the "invention of
the modern hospital" scholars writing "revisionist" hospital histories generally agree with Morris Vogel that:

The evolution of the hospital should not be understood as yet another milestone on the "march of medical progress". Institutional changes were neither necessarily progressive nor inevitably mandated by the growth of science and the bettering of medical practice.14

For Vogel and his peers, the "social ecology of the city", shifting class relations, the needs of the medical profession, and therapeutic developments combined to transform the hospital from charitable to scientific institution.

Within this critical tradition several studies have investigated the conditions under which hospitals in Canada took their particular form.15 Andrews' examination of Vancouver's medical community included a chapter on the Vancouver General Hospital (VGH), characterizing its transformation as "becoming more a scientific institution run by experts, less a charitable refuge." Colin Howell's forthcoming examination of Halifax's Victoria General Hospital, along with David Gagan's research on Ontario general hospitals, provide Canadian contributions to the international body of hospital history.16 For nursing history, this scholarship promises to furnish a more precise analysis of the process of hospital formation in Canada than is currently available.17 In the interim, American and English research has established that a variety of forces, not scientific developments alone, determined institutional change and
therefore those same forces must be considered when investigating nursing history.

A second important theme within the social history of medicine has addressed the process whereby doctors became professionalized. Scholarly studies of the professions have debated the characteristics which defined a true professional. Early sociological contributions to this debate emphasized the specialized skills possessed by professionals, the discreet body of knowledge in the command of those uniquely trained and licensed. More recent contributors have challenged this standard interpretation pointing to the social legitimation and authority, rather than knowledge base, needed to gain true professional status. Within medical history this debate took a particular form. Traditional histories of medicine celebrated the pioneer practitioners who blazed the trail of scientific medicine and won for all doctors public support for professional legislation. Revisionist historiography has offered a very different explanatory model. In this international body of literature five general claims are made about the professionalization of medicine in the nineteenth century: 1) that medical schools were reorganized and socially-marginal applicants were not admitted; 2) that doctors earned the right to define what constituted medicine, and to determine which practitioners in the health care hierarchy could perform which tasks; 3) that the medical profession prosecuted, or persecuted, those practitioners working outside medically-assigned roles; 4) that doctors assumed
leadership for health care institutions, in particular general hospitals; and 5) that doctors were redefining their social and legal role within the socio-economic context of the emerging industrial-capitalist order and its emphasis on experts, managers and centralized authority. ¹⁹

Canadian contributions to this literature have concurred that science *per se* played a less important role in medical professionalization than earlier analysis had suggested. Colin Howell's publications on the medical profession in nineteenth-century Maritime Canada asserted that regular doctors were greatly divided over scientific therapeutics and that economic and social imperatives to eliminate competition from homeopaths, chiropractors and midwives proved greater impetus to gain professional legislation than did scientific certainty. Research, such as that by Charles Roland, demonstrated that the scientific revelations which transformed medicine in the late nineteenth century, such as Lister's antiseptic surgical techniques, were slow to be embraced by many practitioners. In Canada, doctors had gained professional status long before the twentieth century when the theories, which were to become the cornerstones of scientific medicine, were still being debated. These reformulations of the professionalization process have demonstrated that, in the words of Sam Shortt,

...the evolving relationship between the medical profession and its reservoir of knowledge was not by any means the only
significant factor in the professionalization process; economic aspirations, demographic shifts, and alternations in disease patterns, among other considerations, must share responsibility.\textsuperscript{20}

Canadian scholars such as Shortt have agreed with their colleagues elsewhere that scientific medicine was but one of several social forces aiding medical professionalization.

For nursing history, two problematics emerged from the "professionalization" debate within medical history. First, did nurses command a special body of knowledge which, by conventional standards, defined professionalism? And secondly, did nurses achieve the social legitimation which characterized true professionals within the revisionist scholarship? The question of professionalism is certainly not new to nursing history. The professional strategies of organizations and their leaders dominated the pages of nursing textbooks and scholarly studies published throughout his century.\textsuperscript{21} Authors of the nursing text, \textit{Trends in Nursing History: Their Relationship To World Events}, Elizabeth Jamieson and Mary Sewell explained to their student readership that while trade unions battled over hours, pay, and working conditions, professional organizations "aimed to give ever better service to the public through constant improvement in methods of education for service, together with protection of public, doctor and nurse from invasion of its field by unqualified workers."\textsuperscript{22} While these conventional histories accept that nurses' legislative authority and
growing scientific content of their work equalled professional status, other authors claimed that nurses were "semi" or "para-professionals" and had yet to gain the full authority accorded to doctors, lawyers or engineers.  

The preoccupation with characterizing nurses' professional status has drawn criticism within the "new nursing history" arising internationally. In her 1979 doctoral thesis from Brown University, "Skilled Hands, Cool Heads, and Warm Hearts: Nurses and Nursing 1920-1960", and then in her 1982 monograph *The Physician's Hand: Work Culture and Conflict in American Nursing*, Melosh argued that nursing, cannot become a profession, nor should it try. According to Melosh, not only has the professional status of doctors relied on the subordination of the nursing workforce, but the concept of the dedication to service upon which male professionalism rests, has very different implications for women. She maintained that the cultural definition of gender meant that:

Men, to establish their professional legitimacy, had to assert a stronger claim to service; women, to achieve the same end, had to escape the diffuse notion of womenly service.

Further, any increases in power and status gained by American nurses were, argued Melosh, a reflection of the introduction of subsidiary workers over which nurses claimed some authority, rather than a sign of any dramatic improvement in the social or legislative measures of professionalism. Nurses' relative
superiority over subsidiary workers has produced only the illusion of professional status and at the same time divided nurses from those other workers. Professional aspirations, wrote Melosh,

...proved both unproductive and divisive. Adopting the exclusionary tactics of professionalization, leaders sought to secure the privileges of a few at the expense of many. As women they could not hope to win the privileges of a profession, and as aspiring professionals they cut themselves off from the broader support that a more inclusive program could have provided.

Melosh's research also illuminated another problem that the uncritical acceptance of leaders' professional claims has created for historians. Looking for evidence of the success or failure of particular legislative or organizational manoeuvres, researchers have often overlooked the divergent approaches to nursing work adopted by nursing's less-articulate majority. In The Physician's Hand the author invokes the concept of women's work culture to capture the attitude of rank-and-file nurses.

Rooted in the apprenticeship tradition of the hospital schools, nurses' work culture valued careful craft methods, practical experience, and self-control. This was nursing's mainstream; professional ideology was an influential but minority position, even an aberration.

Melosh's challenge to the current nursing leadership to learn from the past and develop a strategy for change which is less-
exclusive and places nurses' interests in line with those all working-class care-givers was taken up by American historian Susan Reverby. Reverby's 1987 publication *Ordered to Care: The Dilemma of American Nursing, 1850-1945* began with the nineteenth century to confront the initial relationship between trained nurses and the political economy of the American hospital system. While Reverby agreed with Melosh's general assessment of professionalism's failure to serve nurses' needs, she was somewhat more sympathetic to nursing leaders' difficulties in finding a way other than professionalism to value nursing care. Examining "the failure of our society to create the conditions under which the desire to care can be valued," Reverby insisted that "nurses, whatever else can be charged against them, continuously try to meet their obligations to care," but that achieving a basis for political unity, professional or otherwise, was fractured by "patriarchal constraints from above and differences among women from within."  

The work of Melosh and Reverby, along with that of English scholars such as Celia Davies and Christopher Maggs, challenges Canadian nursing history to re-assess developments within the occupation in light of the questions raised by the international medical and nursing scholarship. Have Canadian nurses been more successful in gaining professional status than their sisters elsewhere, or has a different vision shaped Canadian nurses' actions and attitudes? How has the political economy of Canadian health
care influenced and been influenced by nurses work? In many ways the Canadian historiography of nursing history has paralleled the pattern in Britain and the United States.27

Only one overview of Canadian nursing exists. Since its publication in 1947, John Murray Gibbon and Mary S. Mathewson's *Three Centuries of Canadian Nursing* has served as the standard historical study. Gibbon, prolific author of non-fiction works such as *Scots in Canada* and the Governor-General's Award winning *Canadian Mosaic: The Making of a Northern Nation*, collaborated with nursing administrator and educator Mary S. Mathewson, to write the heroic tale of Canadian nurses since European settlement in the seventeenth century. The weaknesses of the Gibbon-Mathewson monograph lay in its tendency to describe rather that analyze and in its lack of footnotes. These errors of omission were, however, more than compensated for by the impressive range of research and the authors' ability to place nursing developments within the larger social forces of the different epochs. Gibbon and Mathewson's periodization -- the three-hundred years of European habitation -- indicated the implicit conclusion that continuity, rather than change, defined nurses' experiences, a continuity based on dedication in the face of difficult conditions. In the authors' own words,

...from the day on which the Augustinian Sisters landed at Quebec, nursing in this country has often been a dangerous trade requiring supreme courage and devotion on the part of those who plied it.28
The assertion that nurses have constituted a powerful, but unacknowledged, force in Canadian history was supported by the sheer volume of information Gibbon and Mathewson amassed. As would be expected of such a study written and published during years which would prove to be a critical transition point, the final chapters on events since 1918 were the least satisfactory, presenting less of an historical portrait and a more of a journalistic report. In their words:

"History today is written largely in news-despatches from eye-witnesses, and...such despatches have been quoted frequently, together with personal descriptions of experiences in war or peace by those concerned."

Living and writing during a period of dramatic changes in Canadian health services, Gibbon and Mathewson lacked the historical distance to analyze the significance of the interwar decades for nursing.

Other monographs have focussed on histories of particular groups or individuals. Biographical studies of Ethel Johns, Eunice Dyke, and Kathleen Russell, as well as autobiographical works by Eileen Flanagan, Jean Ewen, B.J. Banfill and Rahno Beamish portrayed the many roads taken by Canadian nurses. Nicholson's 1977 monograph *Canada's Nursing Sisters* celebrated nurses' participation in and contributions to Canada's military operations from the Riel Rebellion to the Korean conflict. A different kind of dedication
was depicted in Joyce Nevitt's *White Caps and Black Bands: Nursing in Newfoundland to 1934*. Her local study of nursing services in what was to become Canada's tenth province emphasized nursing conditions very different, though equally as challenging, from those faced by Nicholson's army sisters. While much valuable material is contained within these studies of individual nurses or particular groups, the authors were generally uncritical of nurses' work and rarely placed changes in the broader social context.

A similar problem limits the usefulness of the body of associational and institutional histories, often inspired by the anniversary of a hospital or organization's founding. A series of hospital and training school histories appeared in the 1940s and 1950s when many institutions or schools celebrated their silver or golden jubilees. H.E. MacDermot's *History of the School for Nurses of the Montreal General Hospital*, Anne S. Cavers' study of the Vancouver General Hospital training program *Our School of Nursing 1899 to 1949*, Marjorie Dobie Munroe's *The Training School for Nurses, Royal Victoria Hospital 1894-1943*, and Ethel Johns' *The Winnipeg General Hospital School of Nursing 1887-1953* exemplified this genre of history commissioned by a school and written by personalities connected to the various institutions. Over the past twenty years many more hospital histories have appeared in published form. Works such as *Our Hospitals Through the Years, Eighty Years of Grace, A Vision Fulfilled: The Story of the The Children's Hospital of Winnipeg 1909-1973*, *BGH100: A History of*
Brandon General Hospital 1883-1983, and Mount Carmel Clinic: A History 1926-1986 joined Johns' earlier publication in chronicling the achievements of Manitoba institutions. Such studies presented, often in a very innocent fashion, much anecdotal evidence portraying the dramatic changes which have occurred within health services over the past century. In general they organized materials so as to impress upon readers medical institutions' triumph over adversity.

Similar volumes were published by provincial nursing organizations. Like the hospital studies, associational histories emphasized pioneer victories over hardship, and success as measured by growth in range of services and number of members. For example Marguerite E. Robinson's The First Fifty Years chronicled the establishment and activities of the Saskatchewan Registered Nurses' Association, an organization which according to Robinson "owes its inception to a few far seeing nurses who realized the necessity for some means to control and regulate nursing standards in Saskatchewan."35 Edouard Desjardins' Heritage: History of the Nursing Profession in Quebec from the Augustinians and Jeanne Mançe to Medicare made similar claims, arguing that nurses of both "founding racial groups" in the province "[defied] early handicaps of poor communications and disruptive external pressures...to promote some of the most advanced legislation achieved by any professional association anywhere."36 This type of nursing history, written "without literary pretension or philosophical digression" assumed
the validity of organizational and institutional goals and critiqued only those forces impeding the authors' vision of progress.37

Authors writing from within university nursing schools have endorsed the definition of progress as the achievement of professional status. On the occasion in 1974 of the University of Alberta Hospital and School of Nursing's fiftieth anniversary, Margaret M. Street, assistant to the director of the University of British Columbia School of Nursing, best known for her biography of that school's first director, Ethel Johns, wrote:

Looking back over the past one hundred years, one sees the gradual evolution of nursing as a profession from embryo to maturity.38

She concluded her review of historical developments in Canadian nursing with an acknowledgement of the many changes scientific and medical innovations would bring to nursing, but also with the inspirational message:

The clear indications are that the nursing profession in this country has come to full maturity and will have the ability and strength to go forward with confidence and pride in its heritage.39

Other commentators, distinguished by academic credentials and long years of nursing practice, were somewhat more ambivalent about nursing's procurement of professional status. To commemorate the first half-century of the University of Toronto School of Nursing, former dean of women at University of Toronto's
University College, Mary Quayle Innis, was invited to edit a collection of essays, entitled *Nursing Education in a Changing Society*, contributed by Ontario's leading nursing educators and academics. Professional strategy and status emerged as key issues throughout the volume.\(^{40}\) Dorothy J. Kergin, Professor of Nursing at McMaster University, wrote "professional status and the concept of professionalism have been of increasing concern to nurses during recent decades." According to Kergin, "through the past century, nursing has evolved from a domestic service...to its present position as nearly a full-fledged profession" [my italics]. Yet as she went on to point out, the process would not be complete until nurses themselves revised their self-image.

Nursing is as highly professionalized as it believes itself to be. Faith in its precepts and foundations, confidence in its ability to change and innovate, wisdom in its choice of leaders, and a continuous desire to serve society's health and illness needs -- if united in these, then nursing need have no doubts about its professional status.\(^{41}\)

Alluding to the increasing frequency with which nurses' professional status was being questioned, Kergin prescribed faith and self-confidence as antidotes to nurses' shaken identity. Kergin's co-contributors emphasized much more tangible measures of professional success. Dorothy G. Riddell's "Nursing and the Law: The History of Legislation in Ontario" and Helen M. Carpenter's "The University of Toronto School of Nursing: An agent of change" pointed
to the legislative and educational advances made by nursing since the 1920s, while M. Kathleen King's "The Development of University Nursing Education" celebrated the emergence of a "scientific body of knowledge" upon which a "theory rather than technique oriented" profession could build. Nurses working within the university nursing schools presented a model of historical development which focussed upon legislative and educational advances as a precursor to demanding increased nurses' academic credentials and developing a unique body of knowledge as the catalysts to win, for once and for all, professional authority.\textsuperscript{42}

Meanwhile, Canadian academics trained in historical rather than nursing research methods were approaching nursing history from a different perspective. Some endorsed the model of the "road to professionalism" promoted within nursing schools. For example, Linda McIntyre's 1984 M.A. thesis in history, "Towards a Redefinition of Status: Professionalism in Canadian Nursing 1939-45", concluded that:

\textbf{The critical self-appraisal of professional education and roles, undertaken by nurses and nursing associations during the war, provided a firm foundation for postwar demands for status. The [nursing] profession had come to realize the legitimacy of seeking public recognition of nurses as co-partners, not subordinates, with doctors and administrators in the nation's health care system.}\textsuperscript{43}
McIntyre's assertion that war-time shortages provided nurses with an opportunity to develop professional aspirations and at the same time prove their worth to an accepting medical community contrasted sharply with the views of researchers such as Joanne Whittaker. In "The Search for Legitimacy: Nurses' Registration in British Columbia, 1913-1935," Whittaker documented nursing leaders' consistent commitment to achieving professional autonomy and an equally consistent resistance on the part of male doctors and legislators to nurses' legal authority. Whittaker's detailed narrative of British Columbia nurses' twenty-two-year battle to win legislative self-government revolved around opposition from "groups of men, doctors and legislators, who objected to women having control over their own profession." While McIntyre and Whittaker disagreed on both the timing and inspiration for professionalization, they shared a common preoccupation with the process whereby nursing leaders engaged in professional strategies.

Two Canadian studies have questioned the validity of professionalism as a strategy worth pursuing at all. Judi Coburn's provocative article "I See and am Silent: A Short History of Nursing in Ontario" described the harsh working conditions early twentieth-century nurses experienced, and critiqued professionalism for its elitist and ultimately unsuccessful approach to improving the quantity and conditions of work. Suzann Buckley's contribution to A Not Unreasonable Claim: Women and Reform in Canada 1880s to
1920s challenged nurses’ professionalism for different reasons. Documenting health reformers’ unsuccessful attempts in the post-World War I years to import British trained midwives to Canada, and therefore decrease maternal mortality, Buckley asserted:

Despite [nurses’] professed concern for prairie women, other factors, especially professional needs, were more important.46

Nurses’ much applauded dedication to service ended when their own professional exclusivity was threatened.

The work of Coburn and Buckley has received little response from subsequent historical scholarship.47 True, their critique of patriarchal relations within the health care system has been endorsed by researchers such as those working out of Dalhousie University’s School of Nursing. In a series of oral interviews with retired nurses who trained and worked in Maritime Canada during the 1920s and 1930s, the Dalhousie team investigated the content of nursing practice.48 Puzzled as to how to characterize nursing work, the research group posed the question "Nurses' Work: Scientific or 'Womanly Ministering'?" Concluding that nursing was as scientific as any health service of their day, the authors asserted that the devaluation of nursing work was part of the more wide-spread cultural devaluation of all women's activities. By stressing the persistent paternalism which has characterized Canadian health care, these authors emphasized the parallels between the sexual division of labour in health services and that of "other" spheres of
social life". However, while willing to critique hierarchic relations between the sexes, the research group stopped short of addressing the significant divisions among nurses and among health care workers which professionalism itself promoted.49

Feminist historians have appeared reticent to pursue an academic critique of professionalism for two reasons. Firstly, such a critique would challenge the commitment to higher education maintained by the current generation of nursing leaders, a generation for whom feminism has become increasingly important. In its present form this dedication to university accreditation has spawned the CNA and Canadian schools of nursing policy that by the year 2000 A.D. the category of RN will be eliminated and, instead, all nurses in Canada will be university-educated Bachelors of Nursing. For historians of women, the feminist sensibilities of nursing leaders presents a dilemma. If, as Melosh has argued, professionalism divided women so too does its critique threaten the toehold feminism seems to have gained in the Canadian nursing academy. Echoing the sentiments presented in American Janet Muff's "Why doesn't a smart girl like you go to medical school? The women's movement takes a slap at nursing"50 the research group from Dalhousie University's School of Nursing suggested the potential power nurses might bring to the women's movement:

Nurses have not been thought of as a group of working women who are radical feminists. Yet their large numbers give them a strength
which has been relatively untapped in the modern day world.51

Nurses and their leaders, celebrating their final victory over sexism in the academy, might interpret a scholarly critique of professionalism as feminist disregard for nursing work: real feminists don't become nurses.

Beyond the desire to promote the feminist alliance between nurses and academics that such research promoted, a second difficulty has limited the scholarly critique of professionalism. The very term "professional" connotes all the positive features of the work which nurses themselves valued. To be called professional evokes concepts like dedication, ethics and quality of service. There is no doubt that by this definition the large majority of nurses could be termed "small p" professional. Indeed, many nurses, old and young, explain their behaviour and attitudes in terms of their professional commitment to patient care.52 But this general descriptive term differs substantially from the "capital P" status which grants groups like the medical and legal professions both the responsibility for and authority over their sphere of influence. Nurses possessed only one-half of the formula which has granted "large P" professionals legislative control over education, licensing and discipline -- in short, self-regulation. Canadian nursing history has failed to distinguish between the informal dedication to service embraced by many service workers and the formal social power wielded by those with legal and political authority. This tendency to
conflate the two uses of the term has resulted in a body of nursing scholarship which focusses on the leadership elite of Canadian nursing to the exclusion of ordinary practitioners far removed from legislative and educational struggles. The experiences of "rank and file" nurses and their role as the medical workforce are significant not only in writing a more complete history of nursing, but also when assessing the ways nurses themselves have constituted a key force within the political economy of Canadian health care. In order to accomplish this end, a third body of scholarly literature, that of women and work, offers critical insights.

In the twentieth century, a long tradition of historical studies in the English language have addressed the issue of women and work. The publication of studies such as Edith Abbott's 1909 *Women in Industry: A Study in American Economic History*, Alice Clark's 1919 *Working Life of Women in the Seventeenth Century* and Ivy Pinchbeck's 1930 *Women Workers and the Industrial Revolution 1750-1850* reflected the curiosity of an earlier generation of feminist academics with the impact of waged labour and industrial production on women's lives. Feminist scholars of the 1960s and 1970s built upon this tradition and produced monographs such as Louise Tilly and Joan Scott's now-standard text *Women, Work and Family*. Posing the question "how has industrial-capitalism influenced women's productive and reproductive work," a new generation of academics have confronted the perplexing problem of women's subordinate economic and social role in paid and unpaid
labour. Feminism's political and theoretical commitment to analyzing the subordination of women has been combined with the theoretical and empirical approaches to social relations of production espoused by labour historians. Out of this union, four areas of inquiry have emerged to dominate recent discussions of women and work; the segmented labour market, deskilling of the labour process, class consciousness and culture, and labour organizations.

The question of the persisting sex-typing of jobs and gender-segmentation of the labour market has preoccupied many feminist scholars in Canada and elsewhere. If profit is the motivating force behind industrial capitalist order, and if labour is one of the few costs which is not fixed, why do capitalists support the division of the labour market along sex lines? Such divisions limit employers' ability to interchange and replace workers, thereby increasing the bargaining power of some workers. In her 1982 publication Labour Pains: Women's Work in Crisis Canadian sociologist Pat Armstrong provided a comprehensive overview of the many answers proposed to the perplexing question of sex-divided workplace and workforce. In general, these theories focus on how capitalism and patriarchy, together or separately, function to structure women into low-paying, low-status jobs. American historian Ruth Milkman has charged that such analyses were more useful for their descriptive than explanatory power.
For the early Marxist-feminists the domestic division of labor determines women's location in wage work. For the segmentationists, dualism in the marketplace determines the sexual division of labour. And finally...patriarchal power, manifest in such organizational forms as exclusionary unionism, determines "woman's place" in the labour market.57

To correct the tendency of theoreticians to "lapse into determinism," Milkman called for the historical examination of the process defining certain occupations as "male" or "female". In her monograph Gender at Work: The Dynamics of Job Segregation by Sex during World War II Milkman examined two American industries during the Second World War and discovered that once occupations were sex-typed, dislodging that ideological positioning was very difficult. In industries dominated by men, conflict arose between male and female workers when women threatened to replace men. However, in industries wherein both sexes already worked, conflict developed over the boundaries between "male" and "female" jobs.

Milkman's model poses an intriguing problem for nursing history. Unlike clerical work, which, as Graham Lowe and Marjory Davies have demonstrated, was the most dramatic example of a "feminized" occupation and industry,58 nursing did not require the "world turned upside down" to ensure its sex-typing. Before its transformation to waged labour in the late nineteenth century, nursing was already labelled as women's work, and the presence of
male nurses is a recent and still relatively rare occurrence. Nursing was women's work. This thesis argues that the patriarchal gender division of labour thus served to emphasize the differences between doctors and nurses, men and women. Class and gender served to define nurses' role as the medical workforce. But if the lines between doctors and nurses were clearly drawn, the lines between nurses and untrained or informally trained nurses in the community were not. During the economic crisis of the 1920s and 1930s, Canadian nurses struggled to differentiate their work from maternal care, and to have their services valued in the health care marketplace.

A second related historical proposition addresses the relationship between the labour market and the labour process. Harry Braverman's seminal work Labour and Monopoly Capitalism: The Degradation of Work in the Twentieth Century argued that through the process of "deskilling", capitalists and managers divorced the conception of work from its execution, retaining decision-making and control over production for themselves and relegating the execution of a vast array of repetitive tasks to wage-earners. Deskilling decreased workers' control over production and at the same time improved employers' ability to replace workers and increase profit. For nursing history, Braverman's proposition is useful in analyzing the reformulation of nursing and medicine that occurred in the late nineteenth century. By 1900, doctors in Europe and North America had achieved professional status, and with it the
authority to define the division of labour within health services. The medical profession retained control over the conceptualization of health -- the powers of diagnosis and prescription -- and relegated the execution of specific duties to subsidiary workers. Throughout the 1920s and 1930s the largest group of subsidiary workers was comprised of student and graduate nurses. By Braverman's definition then, nursing can be described as having been deskillled in the late nineteenth century.

However, two critiques of Braverman suggest that the process of deskillling and the very definition of skill need to be considered further. First, researchers in women's work history have demonstrated the many ways workers reformulated skills so as to create new sources of resistance to the routinization Braverman documented. Susan Porter Benson's 1986 study of sales clerks in American department stores Counter Cultures: Saleswomen, Managers, and Customers in American Department Stores, 1890-1940 argued that, in spite of their lack of any skilled training or tradition, those young women used the skills they developed on the job as leverage against exploitation by owners and managers. Pointing out that "in the department store, the two-way interaction between workers and managers became a complex triangle of saleswomen, managers and customers," Porter Benson highlighted the defining feature of service work, the active role of the "client". Important as the social relations of service were and are, the "working knowledge" women developed while serving their clientele
was often "grounded in social interaction...and is thus doubly devalued."63

As historians like Porter Benson uncovered evidence contradicting Braverman's determinist model, so too have feminist scholars such as Jane Gaskell questioned the implicit definition of skill upon which Braverman based his work. In "Conceptions of Skill and the Work of Women: Some Historical and Political Issues," Gaskell critiqued Braverman for defining skill in terms of length and type of training, and argued instead that "the time and form that training for a job takes are created through a process of political struggle between workers and capital."64 The very definition of skill is a social construction; the absolute difficulty of a job is less important than the ability to win economic recognition for it. Gaskell concluded that "the 'skilled' label...stands for a political process in which some workers have more economic power than others," and that

we should not accept the notion that the only way to become a skilled worker is to do the jobs men do, the way men do them. Organizing to demand recognition of the skills involved in women's labour is critical....65

Considering together these two critiques of skill, the question arises, were nurses skilled workers? This thesis asserts that nursing skill must be defined in two ways. First, nursing practice was based on the theoretical understanding and practical application
of the germ theory, and thus was, by definition, scientific. However, nursing practice must not be considered simply as an extension of scientific medical practice. While nursing was dependent upon medical sanction of nursing techniques, nurses themselves redefined science in a way which permitted the integration of both caring and curing. Nursing work in the 1920s and 1930s served to assist medical therapeutics, but also transcended the role of "physician's hand". Nurses in interwar Canada had less difficulty defining the parameters of their skills, than winning social and financial recognition for their work.

Evidential and theoretical challenges to the concept of deskillling contributed to a third debate with women's work history. Authors like Porter Bénsen have argued that in developing skills with which to resist exploitation women created a larger "women's work culture" developed at the workplace. Drawing upon the "culturalist" school of labour history and its insistence upon the rich and vibrant working class culture from which workers in industrial capitalism drew their pride and collective strength, proponents of the "women's work culture" have claimed a similar workplace pride and identity for their historical characters. American historian Susan Porter Benson defined this concept as follows:

The concept of work cultures [is] the ideology and practice with which workers stake out a relatively autonomous sphere of action on the job.... Work culture is created as workers confront the limitations and exploit the possibilities of their jobs; it is transmitted
and enforced by oral tradition and social sanctions within the work group. Generated partly in response to specific working conditions, work culture includes adaptations and resistance to these cultural constraints.66

Responding to this and the multitude of other cultural forms invoked within labour history, Canadian historian Ian MacKay has critiqued the concept of culture, in either its class or workplace forms, for being so amorphous as to be useless. For McKay the recent tendency to "fashion however many cultures we want; indeed, every oppressed group must have one" begs the question "what constitutes the 'proper' use of so imprecise and vague a differentiation term?"67 Did Canadian nurses develop a distinct women's work culture? Research undertaken for this study suggests that in some ways the experiences, attitudes and actions of the women who trained and worked as nurses in the 1920-1940 years did constitute work culture. Within the "relatively autonomous" sphere of day-to-day patient care, nurses did define their skills such that caring and curing were valued. As well, nurses' self-definition was transmitted and enforced within the workgroup, and between generations. And nurses did demonstrate both adaptation and resistance to structural and cultural constraints at the workplace. However, McKay's critique of the concept does raise two particular questions about the applicability of the term. First, in emphasizing the importance of workplace experiences and actions, the concept of work culture fails to embrace the importance of nursing to women
long after they left paid work. And secondly, for a group of women who have created such an extensive organizational structure to represent their interests, work culture fails to capture the specificity of the powerful occupational identity, of the consciousness, demonstrated by the third generation of Canadian nurses.

One of the standard measures of consciousness has been participation in unions. The failure of many working women to take an active role in existing unions, or develop their own collective voices has been the topic of much debate within women's and labour history. Canadian historian Wayne Roberts has argued that structural features, in particular the high turnover of the female workforce and the isolated conditions in which most women worked, inhibited the union activity of Canadian women. Feminists have charged that overt and covert sexism within the union movement has limited women's union participation or leadership and has undermined women's efforts at collective action. Subsequent research, such as that by Julie White, Ruth Frager, Joan Sangster and Linda Kealey, has revealed that Canadian working women were more militant than traditional labour history indicated, and that women's union involvement was more complex than earlier feminist critics implied. Research on nurses raises a new question regarding the collective action taken by women in the workplace. The extensive organizational network created by nurses did not fit the mould designed by trade unions, nor did the generation of nurses under
study here form significant organizational ties with the trade union movement. Yet the corporate bodies established by the first three generations of Canadian nurses were committed to improving nurses' conditions at the workplace, and engaged in many of the same battles as did workers in the trades. How can nurses' collective voices best be understood? Does the history of nurses' organizations in the interwar years suggest that nurses thought of themselves as professionals, or as members of the working class?

This thesis argues that professionalism was one strategy to which nursing leaders turned, but that many working nurses demanded a different strategy, one which would address the day to day issues of the workplace. Neither professionals nor working class, Canadian nurses in the interwar years appear to be, in the words of Stephen Jay Gould, "a most ingenious paradox". Referring to a historical process far removed from the world of twentieth-century nursing, Gould's essay on a conundrum of natural science -- are siphonophores colonies or organisms? -- offers some relevant insights into the usefulness of historical categories. Gould writes:

...we inhabit a universe of structure. But since our universe of structure has evolved historically, it must present us with fuzzy boundaries, where one kind of thing grades into another. Objects at these boundaries will continue to confuse and frustrate us so long as we follow old habits of thought and insist that all parts of nature [read history] be pigeonholed unambiguously to assuage our poor and overburdened intellects.
Were nurses professionals or working class? Like Gould's siphonophores, the paradox of Canadian nursing in the interwar years does have an answer: "the answer is that we asked the wrong question." \(^7^3\) Nurses are both and neither. Borrowing from concepts of professionalism and trade unionism, concepts created for and by a male workplace experience, nurses in interwar Canada confronted a workplace structured by class and gender. As women workers, they searched for an organizational model which would speak to the realities and diversity of their workplace experiences.

These four areas of historical inquiry -- the sex-specific composition of the Canadian nursing workforce, definition of nursing skill, occupational consciousness, and the organizations developed to represent that consciousness -- demand that researching Canadian nursing be approached from an angle different from that taken by traditional medical or nursing history. The "great doctors" and self-sacrificing nurses who filled the pages of conventional historical studies no longer attract the attention they once did. Instead, the issues of social relations among workers, between classes, and between the sexes, well-established within the historiography of women and work, have begun to influence investigations into the social history of health care. By investigating the world of the ordinary Canadian nurse, this study explores the experiences of the medical workforce as it confronted the economic crisis of the 1920s and 1930s, and analyzes the impact of nurses' agency in
transforming the health care system. In doing so this thesis draws on and contributes to the historical literature on the social history of medicine, nursing, women and work, and aims to place nursing history in history.
1 E. Fox-Genovese "Placing Women's History in History," New Left Review, 133 (May-June, 1982): pp. 5-29. Fox-Genovese asserts that "the inclusion of women within conventional historical narratives cannot be dismissed lightly... But adding women to history is not the same as adding women's history." (p. 6). Her challenge to women's history is echoed by Veronica Strong-Boag and Anita Clair Fellman, Rethinking Canada: The Promise of Women's History (Toronto: Copp Clark Pitman, 1987) who argue historians of Canadian women are motivated both by a desire to "place ourselves in time, to tie ourselves to those who came before us" but also because "we cannot pretend to reconstruct a reasonable history of the Canadian people by ignoring the lives and participation of half of them. History without women is, of necessity, a distorted history." (pp. 1-2).


8 S.E.D. Shortt, ed., Medicine in Canadian Society: Historical Perspectives (Montreal: McGill-Queen's University Press; 1981); Charles Roland, ed., Health, Disease and Medicine: Essays in Canadian History (Hannah Institute for the History of Medicine, 1984); Wendy Mitchinson and Janice Dickin McGinnis, eds., Essays in the History of Canadian Medicine (Toronto: McClelland and Stewart, 1988). Perhaps recognizing the omission of nurses from their volume, Mitchinson and McGinnis selected for the front cover a photograph of a nurse obviously in a hospital setting attending an infant. Such photographs of nurses actually working are relatively rare in comparison to those of nurses posing for graduation or on hospital lawns.

9 Douglas Baldwin's "Smallpox management on Prince Edward Island, 1820-1940: From neglect to fulfillment," Canadian Bulletin of Medical History 2, no. 2 (Winter 1985): pp. 147-81 was a rare exception to this. The Canadian Society for the History of Medicine's active encouragement of nursing research promises to rectify the dearth of nursing submissions to their Bulletin.

David Gagan, "For "Patients of Moderate Means": The Transformation of Ontario's Public General Hospitals, 1880-1950" Canadian Historical Review LXX, no. 2 (June 1989): pp.151-179. Gagan's work resembles that of Charles Rosenberg's research on the American hospital system. Rosenberg also recognized nurses' contributions, writing "In 1800, as today, nurses were the most important single factor determining ward and room environment." However, Rosenberg also argued that "nursing, like professional hospital administration and changed modes of hospital financing" were important but subordinate to the role of the medical profession in shaping the modern hospital. Whether Gagan will continue to pattern his analysis after that of Rosenberg remains to be seen.


Morris J. Vogel, The Invention of the Modern Hospital, 1870-1930 (Chicago: The University of Chicago Press, 1980), p. 4. No debate has developed regarding the causal factors of the transformation of hospitals from charitable to scientific facilities such as the debate which has surrounded historical investigations into the rise of asylums, the institutions sociologist Andrew Scull termed "Museums of Madness". Andrew Scull, Museums of Madness (London: Allen Lane, 1979).


17 The lone overview currently available is Harvey Agnew's Canadian Hospitals, 1920 to 1970: A Dramatic Half Century (Toronto: University of Toronto Press, 1974). Dr. Agnew left private practice in 1928 to head the Canadian Medical Association's Department of Hospital Service. His long association with organizations like the Canadian Hospital Association and with individuals such as Dr. Malcolm T. MacEachern of the American College of Surgeons provided him with many personal insights into hospital structure and administration, upon which he based his monograph.

18 Standard analyses of professionalism emphasized the specialized body of knowledge and dedication to service which defined "true" professionals. Sociologist Eliot Freidson revised this definition, pointing instead to the autonomy over work and the division of labour which true professionals gain through social legitimation and which is maintained through the social and legal support of a "sponsoring elite". See Eliot Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Harper & Row, 1970).


22 Elizabeth Jamieson and Mary Sewall, Trends in Nursing History: Their Relationship To World Events (Philadelphia: W.B. Saunders Company, 1944), p. 466.


24 Susan Reverby, Ordered to Care: The Dilemma of American Nursing, 1850-1945 (Cambridge: Cambridge University Press, 1987). In her introduction Reverby stated "I share much of Melosh's perspective but have cast my study back into the nineteenth century and within a broader historical framework of the political economy of the hospital's development." p. 6.

25 Ibid.


28 Ibid, p. vi.

29 Margaret Street, Watchfires on the Mountains: the Life and Writings of Ethel Johns (Toronto: University of Toronto Press, 1973); Marion Royce, Eunice Dyke: Health Care Pioneer (Toronto: Dundurn Press, 1983); Helen M. Carpenter, A Divine Discontent Edith Kathleen Russell: Reforming Educator (Toronto: University of Toronto Faculty of Nursing, 1982); Eileen C. Flanagan, "The Parts of Pisces" in Margaret Gillett and Kay Sibbald, A Fair Shake: Autobiographical Essays by McGill Women (Montreal: Eden Press, 1984), pp. 40-53; Jean Ewen, Canadian Nurse In China (Toronto: McClelland and Stewart


31 Joyce Nevitt, White Caps and Black Bands: Nursing in Newfoundland to 1934 (St. John's, Newfoundland: Jesperson Printing, Ltd. 1978).

32 See, for example, John Lawrence Runnalls, A Century with the St. Catharines General Hospital (St. Catharines, Ontario: St. Catharines General Hospital, 1974). The trend whereby institutions sponsor the writing and publication of their own histories continues. For example, C. Howell's forthcoming history of Halifax's Victoria General will be published by the Victoria General to celebrate its "century of care." Colin Howell, A Century of Care, cited in Howell, "Back to the Bedside".

33 H.E. MacDermot, History of the School for Nurses of the Montreal General Hospital (Montreal: The Alumnae Association, 1940). Dr. MacDermot served as "house surgeon in 1913 and as a student in the hospital before that" and included his own reminiscences of the early days at the Montreal General. His seventy-page history included a selection of letters by Nursing Superintendent and founder of the Montreal General Hospital School of Nursing, Miss Nora Livingstone. The published extracts were from letters written to her two sisters during 1890 and 1891, and although edited so as to avoid "personal material which cannot be published" nonetheless provide fascinating insights into the life of this nineteenth-century career nurse. See also Marjorie Dobie Munroe, The Training School for Nurses Royal Victoria Hospital 1894-1943 (Montreal: The Royal Victoria Hospital, 1943). Dobie Munroe was a graduate of the Royal Victoria class of 1925, and began researching the book in 1932 at the request of Nursing Superintendent Miss Mabel Hersey. The Alumnae Association "decided to publish the book to mark the fiftieth anniversary" of the School. Cavers' history of the Vancouver
General was published with the same intent, and was also written by a VGH alumna of the class of 1927, Anne S. Cavers, Our School of Nursing 1899 to 1949 (Vancouver: 1949). The Winnipeg General Hospital history was published for the Golden Jubilee of the WGH Alumnae Association. Ethel Johns, The Winnipeg General Hospital School of Nursing, 1887-1953 (Winnipeg: 1953).


35. Edouard Desjardins, Heritage: History of the Nursing Profession in Quebec from the Augustinians and Jeanne Mance to Medicare (The Association of Nurses of the Province of Quebec, 1971), p. 11.


38. Ibid, p. 31.

39. Mary Quayle Innis, ed., Nursing Education in a Changing Society (Toronto: University of Toronto Press, 1970), p. v-vi. The list of contributors consisted of academically-accomplished women serving in positions such as professors at the University of Toronto and McMaster University, an Instructor at Toronto Western Hospital's Atkinson School of Nursing, and the Directors of the Canadian Nurses' Association and Victorian Order of Nurses.

40. Dorothy J. Kergin, "Nursing as a Profession" in Innis, Nursing Education in a Changing Society, p. 61.

41. See also Marguerite E. Schumacher, "Technical and Professional - What's in a Name?", in Betsy LaSor and M. Ruth Elliott, eds., Issues in Canadian Nursing (Scarborough: Prentice-Hall of Canada, Ltd., 1977), pp. 73-82 for a discussion of her academic plan for professional development. Schumacher states "foremost is the need to establish that core of knowledge and skills peculiar to nursing. This will be done best by the profession through systematic research." p. 76.
42 Linda B. McIntyre, "Towards a Redefinition of Status: Professionalism in Canadian Nursing, 1939-45" (M.A. thesis, University of Western Ontario, 1984), p. 120. McIntyre's analysis was that after the Second World War "Nurses no longer silently would accept the public image of 'doctor's handmaiden', but actively sought redefinition of professional status on their own terms." p. iv.


46 For example see Yolande Cohen and Michèle Dagenais, "Le Métier D'Infirmière: Savoirs Féminins et Reconnaissance Professionnelle," RHAF, 41, no. 2 (automne 1987): pp 155-177, for a recent study which adopts the conventional emphasis on the professional strategies employed by Quebec nurses in the early twentieth century. Scholars in other disciplines have been more willing to assess critically professionalism. See for example, Marie L. Campbell, "Productivity in Canadian Nursing: Administering Cuts," in David Coburn et al, ed., Health and Canadian Society: Sociological Perspectives, 2nd ed. (Markham, Ont.: Fitzhenry and Whiteside, 1987). Campbell argues that the rhetoric of professionalism hides the real exploitation of nurses, particularly as hospitals try to increase efficiency and productivity during periods of financial strain. p. 473.


51 See. Campbell, "Productivity in Canadian Nursing" for a discussion of nurses' "professional" concern about drawing negative attention to themselves through claiming overtime.


54 Pat Armstrong, Labour Pains: Women's Work in Crisis (Toronto: The Women's Educational Press, 1982). In particular, see Chapter II for Armstrong's discussion of the three main groupings of theoretical approaches: structuralist functionalism, labour market segmentation theory, and socialist feminism.

55 Closely linked to the issue of women and paid work is the "domestic labour debate" which addresses the reasons capitalism has retained privatized "reproduction" of workers within the family. For a useful collection of some of the key elements of this debate see Roberta Hamilton and Michèle Barrett, eds., The Politics of
Diversity: Feminism, Marxism and Nationalism (Montreal: Book Center Inc., 1986).


59 In his 1983-84 historiographic essay, medical historian S.E.D. Shortt stresses the critical links between the transformation of the modern hospital, the professionalization of medicine, and the reorganization of nursing. He argued that changes within nursing were critical to medical dominance of institutions, and that the institutional transformation was critical to medical professionalization: "The formalization of the medicalization of the institution, together with the incorporation of nurses' training schools within the institutions, suggested a growing medicalization of the hospital....[As] patients flocked to these institutions...they ensured the physicians' hegemony in the twentieth-century hospital." Thus, for Shortt, in the nineteenth century the hospital "became a medical institution shaped by the rhetoric of science and the gospel of efficiency. If patients gained in the process, their physicians, in terms of status, power, and authority, made even greater strides." Shortt, "The Canadian Hospital in the Nineteenth Century," pp. 6, 7, & 9. It is important to note, however, that unlike the managerial class in other industries however doctors continued to be active in the day to day "production" of health services, particularly with respect to performing highly technical procedures developed within the field of scientific medicine.
60 Susan Porter Benson, Counter Cultures: Saleswomen, Managers, and Customers in American Department Stores, 1890-1940 (Urbana: University of Illinois Press, 1986).

61 Ibid., p. 6.

62 Ibid., p. 229.


64 Ibid., p. 379.

65 Porter Benson, Counter Cultures, p. 228. See also, Barbara Melosh, "The Physician's Hand" Work Culture and Conflict in American Nursing, (Philadelphia: Temple University Press, 1982), pp. 4-6 for a discussion of this concept.


71 This is not intended to compare nurses with siphonophores. Readers unfamiliar with siphonophores will have to read Gould's essay.


73 Ibid.
Chapter 3
An Occupation in Crisis

While many nurses in the early 1920s proudly celebrated the contributions and advances made by their profession during the First World War, other commentators were beginning to question the domestic system of nursing services. Patients complained about the high cost of nursing care, doctors grumbled about poor quality of assistance, and nurses wondered how they were going to pay their rent, especially if they too took ill. Irregular employment and difficult, if not dangerous, conditions at available jobs began tarnishing the reputation of the occupation which had seemed to promise so much to Canadian women. One 1921 observer bleakly summarized the fate of the average hospital graduate: "Her work is uncertain, she must frequently be idle whether she can afford it or not, [and] years of faithful labour win no recognition." As the 1920s progressed, the downward spiral of increased reliance on hospital services, growth in the graduate nurse population, and reduced demand for domestic health care, sent conventional nursing into a tailspin. The still more generalized economic depression of the 1930s served to accentuate the crisis which began taking form soon after the First World War. In the words of a 1934 Winnipeg General Hospital graduate:

It is with a feeling of secret shame and remorse as well as a good deal of foreboding that training schools of today send their young graduates out, for they know only too well what a barren future awaits them. And
the young graduate herself, no longer is she serenely confident: it is rather with a shrinking feeling of fear that the '34 nurse must face the future.4

Such individual assessments were substantiated by more formal investigations of the forces debilitating the occupation. Agencies such as the Dominion Bureau of Statistics and the Canadian Nurses' Association Survey Committee manoeuvered around the many ambiguities of status and experience which characterized the highly-mobile nursing workforce to establish the size and composition of one of the most popular occupational choices for women workers. The dramatic numerical increase in the nursing workforce over the early decades of the twentieth century indicated nursing's popularity, as did the sociological characteristics of the women lured to it. This chapter introduces the third generation of Canadian nurses. The collective profile of the graduate nurse population challenges the "middle-class" stereotype of the occupation, and asserts instead that nursing attracted women from a variety of family backgrounds who shared more in terms of sex, marital status, race, and education, than a common economic status of their fathers. This chapter also delineates the different work environments available to nurses in the 1920s and 1930s, and examines the differential impact of the interwar economic crisis on the occupation's subsectors. Widespread dissatisfaction with working conditions prompted nurses to seek employment in the more stable sectors of the health care system. By 1940, a large pool of
available practitioners was ready and waiting to participate in the economic transformation of health services that the wartime economy inspired.

The changes affecting Canadian nurses were documented by the many commentators monitoring nursing's rapid pulse. At the national level, two bodies, the Dominion Bureau of Statistics and the Canadian Nurses' Association (CNA), took steps to gather detailed data describing and defining the nursing population of the interwar years, while by the late 1930s some Provincial Associations were following suit with studies of local conditions. Researchers such as Fraudina Eaton who was commissioned in 1937 to investigate working conditions in British Columbia's hospitals quickly discovered that documenting the experiences of such a large and mobile workforce was no simple task. Inevitably, their data displayed strengths and weaknesses. In Eaton's case, for example, uneven availability of institutional records and the variety of sizes of institutions being investigated led her to present very general statements describing British Columbia's hospitals, and no total image of the workforce at any one hospital emerged from her findings. Yet much was discovered through these various inquiries. Of particular value were the 1921, 1931, and 1941 Censuses and the Canadian Nurses' Association's 1932 Survey of Nursing Education in Canada which amassed information regarding the number, distribution, age, education, ethnicity and class background of nurses. When used together, they permit the creation of a collective...
portrait of the workforce, and delineation of the range of difficulties confronting Canadian nurses.

The special strengths of the Sixth, Seventh and Eighth Census of Canada lay in their provision of comparative data for the national pool of nurses. All three contained volumes or tables listing the numbers and various variables of each occupation of the "gainfully employed". The 1931 Census also included one volume entitled Institutions, which investigated the clientele and personnel of every hospital and asylum in each province and territory, and the Federal Bureau occasionally published intercensal updates on Canada's institutional services entitled The Canadian Hospital Directory. For all their appearance of inclusiveness, drawing comparisons from these reports nevertheless required considerable care. There was, for example, a problem of definition. The 1921 Census was satisfied with the broad category "Nurses and Nurses-in-Training" when tabulating data on the nursing population, rather than the more specific categories of "Nurses-Graduate" and "Nurses-In-Training" employed in subsequent reports. As well, even for comparable data, the figures compiled at the beginning of each decade did not illuminate the changes occurring between Census years. This had particular impact on the data on nursing, an occupation which experienced significant mobility of its members within and out of the workforce over the 1920-1940 period. And finally, no Census differentiated consistently between nurses working as supervisors, administrators and public health employees and those labouring as
staff or private duty nurses. The 1921 and 1931 publications differentiated private duty nurses from hospital or public health staff nurses by listing private nurses as workers with their "Own Account" whereas the latter groups were considered "Wage-earners". Beginning with the 1936 Census of Prairie Provinces, "graduate nurses engaged in private nursing were treated as salaried persons," making comparisons of nursing's subcategories meaningless. The substantial difference in status and experience of women engaged in these various sub-sectors of the occupation demanded reference to other sources providing more detailed data in order to assess the general trends suggested by the Census reports.

The landmark Survey of Nursing Education in Canada, the end-product of educator George M. Weir's three-year inquiry into nursing conditions in Canada, took up where the Census material left off, creating as it did a detailed picture of the various sub-sectors nurses inhabited. As early as 1927 officials of the Canadian Nurses' Association were acknowledging that the existing system of nursing practice was in crisis. Association members representing private duty nurses had been lobbying since 1920 for solutions to their problems of long hours, low wages, and scarcity of work, but it was not until complaints were received from doctors regarding nurses' low skill levels, and from patients of nurses' high costs, that the national body was prompted to investigate. A committee of the Canadian Nurses' Association and the Canadian Medical Association (CMA) -- the CNA paying for 70% of the cost but with the CNA and
CMA equally represented — commissioned Dr. George M. Weir of the University of British Columbia to investigate the economic, educational, and sociological problems affecting the quality and distribution of nursing services in Canada. The results of Weir's study, which spanned 1929-1931, were published by the University of Toronto Press in 1932, under the title Survey of Nursing Education in Canada. While the prescription Weir offered for the ailments of Canadian nursing almost exclusively addressed features of the educational system, and meant little for the nurse already in the workforce, the data presented in his report provided rare insights into this occupation in crisis.

One factor precipitating high levels of unemployment was the dramatic growth after 1900 in the size of the nursing workforce. Figure 3.1 summarizes the numbers presented for the profession in the 1891 - 1941 Census reports.
### Figure 3.1
**Number of Female Workers, Nurses, and Physicians and Surgeons.**
*Canada 1891-1941*

<table>
<thead>
<tr>
<th>Census</th>
<th>Women Workers</th>
<th>Graduate Nurses*</th>
<th>Student Nurses</th>
<th>Practical Nurses*</th>
<th>Physicians and Surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1891*</td>
<td>195,990</td>
<td>1,829</td>
<td>280</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>1901</td>
<td>237,949</td>
<td>5,476</td>
<td>11,436</td>
<td>203</td>
<td></td>
</tr>
<tr>
<td>1911</td>
<td>364,821</td>
<td>21,162</td>
<td>270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1921**</td>
<td>490,150</td>
<td>20,462</td>
<td>4,698</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1931</td>
<td>665,859</td>
<td>11,822</td>
<td>7,985</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1941***</td>
<td>832,840</td>
<td>26,887</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* nurses and midwives, after 1891 midwives were no longer listed in the *Census* reports
** graduate and student nurses
*** not including active service

Source: *Censuses, 1911, 1921, 1931, 1941*

What seems clear is that between 1891 and 1901 informally trained nurses and midwives were supplanted by the substantially smaller corps of trained nurses, a shift representing the marginalization of midwifery and the rise of the hospital nursing school. While less than 300 hospital-trained practitioners plied their trade at the turn of the century, by 1921 a 75-fold increase in the number of nurses and students had occurred. The fact that the 1921 *Census* categorized nurses and nurses-in-training together reflected the still uncertain public appreciation of the status of graduate or trained nurses over the untrained or partially-trained practitioner, whereas by 1931 that distinction was firmly in place. The 50%
increase in the total nursing population between 1921 and 1931 was augmented by a further 3% growth during the 1930s. Using a slightly different research method, Weir concurred with the findings of the Dominion Bureau of Statistics. After consulting provincial nursing associations, the UBC professor calculated that a total of 20,916 trained nurses were practicing in Canada as of January 1, 1930. Of this number, 18,174 were Registered nurses and 2,742 were graduate nurses "professionally qualified to register but not on the provincial registries". In addition, Weir tabulated 9,594 student nurses apprenticing in the numerous Canadian programs.

Provincial distribution of nursing personnel remained basically constant between the two wars, with Ontario educating and employing over 40% of the Canadian workforce.
The most noticeable shift in these years occurred in Quebec. There, a 7% increase in the proportion of trained nurses seemed the result of two factors: female members of Catholic orders were encouraged to acquire Registered Nurse (RN) status, and by the 1931 Census, religious workers were being categorized more precisely. For the first time, this Census included nuns with particular education and skills in their respective occupational categories. Only nuns with employment status "not especially stated" fell into the "Nuns and brothers, n.e.s." grouping.

Even in Quebec, where the continued labour of Catholic orders had long ensured a higher ratio of nurses to patients than elsewhere, the rate of increase for hospital-trained personnel far outdistanced that of provincial population growth in these decades. British Columbia was best served throughout the period, both in terms of
graduate nurses per person and total nursing workforce per person. Citizens of Ontario had similar advantages, followed by those in Manitoba, Nova Scotia and New Brunswick. Rapid interwar population growth moved Saskatchewan to the position of the jurisdiction with the lowest supply of hospital-trained practitioners, adding to the difficulties of that drought-stricken province. Census figures for the ratio of nurses, graduate and student, to population attested to the increased availability of certified practitioners to citizens of each province.
The decreased ratio of nurses to population indicated the absolute and relative numerical increases in the nursing workforce during the interwar period.

Improved supply of nurses was part of the more general growth in the early twentieth century of "white collar" occupations designated as women's work. Comparative figures from the 1901-1941 Census reports demonstrated the decline of "manual" occupations such as dressmaking, the relative stability of the domestic servant and teaching categories, and the dramatic
The mercurial rise of the graduate nurse workforce did not compete with that in clerical and office work, whose combined growth rate exceeded 45% in this decade. Stenography, typing, bookkeeping and other office tasks requiring much shorter periods of training before women could enter full time employment were especially attractive although they did not guarantee board and room during apprenticeship nor offer the mobility and prestige of nursing. Most important, as Graham Lowe has demonstrated, was the administrative revolution occurring in Canadian offices, which multiplied many times over the number of available clerical positions. Together these changes in employment opportunities and conditions rearranged the occupational hierarchy, but did not alter the sex-segmentation of the labour market. By 1920 secretarial work, sales positions, and "professional service" such as nursing and teaching were firmly ensconced as favourite vocational options among those occupations designated as women's work.

Like the new secretarial positions created by the administrative revolution, nursing drew on an almost exclusively female workforce. A total of only 450 men appeared in the Census reports for these years, 223 in 1921, none in 1931, and 227 in 1941 of whom 74 were in active service. The few men who did appear in Census data were never reported by other sources, neither in hospital records nor nursing association reports. Certainly, all the
respondents to Weir’s survey were women. The other outstanding occupational characteristic was the unmarried state of most nurses.

Figure 3.4
Marital Status of Nurses, by Occupational Sub-sector, 1929-30

<table>
<thead>
<tr>
<th>SUB-SECTOR</th>
<th>% UNMARRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Nurses</td>
<td>99.8%</td>
</tr>
<tr>
<td>Private Duty Nurses</td>
<td>90%</td>
</tr>
<tr>
<td>Hospital Nurses</td>
<td>94%</td>
</tr>
<tr>
<td>Superintendents</td>
<td>92%</td>
</tr>
<tr>
<td>Public Health Nurses</td>
<td>92%</td>
</tr>
</tbody>
</table>

Source: G.M. Weir, *Survey of Nursing Education in Canada*

The overwhelming percentage of unmarried nurses was not surprising since nurses, like other female wage-earners, were enjoined to leave paid labour upon marriage. This social taboo was formalized by hospitals which would employ only married women who were divorced or widowed. Unlike the Census, Weir did not indicate whether the 6 to 10% who continued to work after marriage were married, widowed or divorced.
The onset of World War II somewhat countered the trend, as hospitals, nursing associations and governments publicly recruited married nurses out of retirement. Throughout most of the 1920s and 1930s, however, most married women who practiced their trade did so on an "on call" basis, particularly in small communities with a limited pool of trained personnel. Many of these "inactive" nurses let their association memberships lapse until they returned to more regular employment, and thus escaped classification by Weir or the

Source: Census, 1921, 1931, 1941
Dominion Bureau of Statistics, though their contributions to community health were verified by association records and oral interviews.\(^26\)

The majority of these single women recruited into nursing were Canadian-born. Figure 3.6 lists the Census data pertaining to nativity of Canadian nurses during the interwar decades.

**Figure 3.6**

*Birthplaces of Nurses, (Canada) 1921, 1931, 1941 by Number and Percent*

<table>
<thead>
<tr>
<th>Birthplaces</th>
<th>All countries</th>
<th>Canada</th>
<th>British Isles + Possessions</th>
<th>United States</th>
<th>Europe</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1921</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>21,162</td>
<td>16,453</td>
<td>3,567</td>
<td>827</td>
<td>283</td>
<td>23</td>
</tr>
<tr>
<td>Graduate &amp; Student</td>
<td>100%</td>
<td>77.75%</td>
<td>16.86%</td>
<td>3.9%</td>
<td>1.34%</td>
<td>.11%</td>
</tr>
<tr>
<td><strong>1931</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses-Graduate</td>
<td>20,462</td>
<td>16,666</td>
<td>2,797</td>
<td>675</td>
<td>293</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>81.45%</td>
<td>13.67%</td>
<td>3.30%</td>
<td>1.43%</td>
<td>.02%</td>
</tr>
<tr>
<td>Nurses-Student</td>
<td>11,436</td>
<td>10,220</td>
<td>783</td>
<td>325</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>89.37%</td>
<td>6.85%</td>
<td>2.84%</td>
<td>.79%</td>
<td>.009%</td>
</tr>
<tr>
<td><strong>1941</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses-Graduate</td>
<td>26,473</td>
<td>23,349</td>
<td>2,103</td>
<td>695</td>
<td>271</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>88.20%</td>
<td>7.94%</td>
<td>2.63%</td>
<td>1.02%</td>
<td>.15%</td>
</tr>
<tr>
<td>Nurses-Student</td>
<td>11,810</td>
<td>11,122</td>
<td>344</td>
<td>217</td>
<td>100</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>94.17%</td>
<td>2.94%</td>
<td>1.84%</td>
<td>.85%</td>
<td>.15%</td>
</tr>
</tbody>
</table>

Source: *Census, 1921, 1931, 1941*

In each Census report Canadian-born women accounted for over 75% of the Canadian nursing population. The increase in the proportion of native-born nurses during the interwar decades was gained at the expense of British-born women.

Whether foreign or native born, most Canadian nurses were white and of anglo-saxon descent. In 1931, 76% of graduate nurses
native-born nurses during the interwar decades was gained at the expense of British-born women.

Whether foreign or native born, most Canadian nurses were white and of anglo-saxon descent. In 1931, 76% of graduate nurses claimed British ethnic heritage, 18% stated French, 5.8% listed themselves as of other European ancestry, another .28% said they were "Hebrew" -- although whether all Jewish women were included in that category or were listed in other national groups is unclear -- and a final .06% were of Indian, Japanese and Chinese origin.27 The virtual absence of women-of-colour in nursing's professional ranks was enforced both by federal immigration restrictions and by the racial discrimination practiced by hospital nursing schools.28 Be they black women in Nova Scotia, Japanese in British Columbia, or native Canadians anywhere, women of colour were usually prevented from enrolling in training programs. For example, Chinese and Japanese women were admitted to the Vancouver General Hospital in the 1930's but only after the argument was made that Chinese and Japanese nurses were necessary to work in those particular communities which were poorly serviced by white nurses. These often unwritten colour bars required substantial opposition before being dismantled, and most remained in existence until after the Second World War.29

Privileged by race and nativity, Canadian nurses were also advantaged by age and education. Census results concerning the ages
of nurses show that for all three Census years the largest concentration of nurses was in the 25-34 age-group. The figures for 1921 were somewhat skewed by the fact that students and working nurses were counted together; the result placed a larger concentration of nurses in the 18-19 and 20-24 age-groups than for the subsequent census reports.

**Figure 3.7**

**Ages of Nurses, Canada, 1921, 1931, 1941**

<table>
<thead>
<tr>
<th>Year</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-69</th>
<th>70+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1921</td>
<td>160</td>
<td>1161</td>
<td>5993</td>
<td>7112</td>
<td>4664</td>
<td>1688</td>
<td>364</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1931</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All nurses</td>
<td>114</td>
<td>2,982</td>
<td>11,706</td>
<td>9,043</td>
<td>4,123</td>
<td>2,598</td>
<td>1,044</td>
<td>189</td>
<td>99</td>
</tr>
<tr>
<td>Graduate</td>
<td>0</td>
<td>8</td>
<td>4,798</td>
<td>7,677</td>
<td>4,057</td>
<td>2,590</td>
<td>1,044</td>
<td>189</td>
<td>99</td>
</tr>
<tr>
<td>Student</td>
<td>114</td>
<td>2,974</td>
<td>6,908</td>
<td>1,366</td>
<td>66</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1941</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All nurses</td>
<td>1</td>
<td>1978</td>
<td>13,302</td>
<td>12,350</td>
<td>5030</td>
<td>3300</td>
<td>1794</td>
<td>343</td>
<td></td>
</tr>
<tr>
<td>185</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRADUATE</td>
<td>0</td>
<td>0</td>
<td>4743</td>
<td>11,132</td>
<td>4978</td>
<td>3298</td>
<td>1794</td>
<td>343</td>
<td>185</td>
</tr>
<tr>
<td>STUDENT</td>
<td>1</td>
<td>1,978</td>
<td>8559</td>
<td>1,218</td>
<td>52</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Source: Census, 1921, 1931, 1941.

Weir's conclusions that the median age of private duty and institutional nurses in 1930 was 31 years, confirmed Dominion Bureau of Statistics' data. A slight shift in the age of workforce occurred from 1931-1941, as the percentage of nurses aged 20-24 dropped by 5% and the concentration of those aged 25-34 grew by 5%. Whether this different age distribution resulted from reductions in the number of student nurses during the 1930s or nurses remaining
actively employed for more years of their careers during the depression decade cannot be discerned.31

Comparisons with other women workers suggested that nurses remained active in the labour force fewer years than all women workers, but longer than women working in clerical occupations, teaching, sales, or communication. Figures 3.8 and 3.9 display comparative data from Census reports.

Figure 3.8
Age Distribution of Women Workers, Canada, 1931
Relative to the majority of women workers, nurses as a group boasted superior educational backgrounds. Entrance standards set by schools of nursing, however flexible, ensured that most students were at least 18 years old before their three-year apprenticeship began. This contrasted sharply with teachers who might well be teaching with a third-class certificate at age 16.

The commonalities of status and experience which defined this young, white, native-born, anglo-saxon, educated female workforce, contrasted with the diverse class backgrounds of its members. As the only study to investigate the occupations of nurses' families, Weir's findings on this question proved invaluable. For each of the
respondents to his written questionnaire, Weir recorded the occupation of the nurse's father or guardian, and then assigned each daughter to one of six categories: unskilled workers, farmers, semi-skilled workers, skilled workers, business and clerical workers, or professional workers. The breadth of some categories weakened his data. For instance, "farmers" included ranchers and fruit growers as well as family farmers and homesteaders, occupations requiring very different kinds of labour and capital to run their operation.35 Similarly, the "business and clerical worker" grouping included both foremen and office-workers, even though their socio-economic status differed greatly. Weir thus underestimated the number of working-class families losing their daughters, and their daughters' wages, to three-year hospital apprenticeships. Despite these limitations, Weir's investigation into class origins repudiated the elite image which many, including Florence Nightingale, had claimed for nursing. Diversity of class background was as important a defining feature of the third generation of Canadian nurses as was commonality of gender.

As Figure 3.10 indicates, Weir's statistics documented the predominance of women from farm homes in all sub-sectors of the occupation. Hospital schools offered room and board, and skilled training and certification -- all the elements necessary for secure passage out of the agricultural economies and their limited roles for women.
### Figure 3.10

**Occupation of Nurses’ Parents or Guardians, 1929-1930**

<table>
<thead>
<tr>
<th>Category</th>
<th>UN- SKILLED</th>
<th>SEMI- SKILLED</th>
<th>SKILLED</th>
<th>FARMER</th>
<th>BUSINESS &amp; CLERICAL</th>
<th>PROF'L</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT NURSES</td>
<td>2.1%</td>
<td>8%</td>
<td>21.1%</td>
<td>38.1%</td>
<td>22.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>PRIVATE DUTY</td>
<td>1.4%</td>
<td>5.4%</td>
<td>17.2%</td>
<td>39.4%</td>
<td>23.3%</td>
<td>13.3%</td>
</tr>
<tr>
<td>HOSPITAL NURSES</td>
<td>1.3%</td>
<td>3.1%</td>
<td>14.7%</td>
<td>35.9%</td>
<td>30.6%</td>
<td>14</td>
</tr>
<tr>
<td>SUPERINTENDENTS</td>
<td>0%</td>
<td>3.8%</td>
<td>10.6%</td>
<td>32%</td>
<td>39.4%</td>
<td>14.4%</td>
</tr>
<tr>
<td>PUBLIC HEALTH</td>
<td>.06%</td>
<td>2.7%</td>
<td>15.6%</td>
<td>28.1%</td>
<td>33.1%</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>.97%</td>
<td>4.6%</td>
<td>15.8%</td>
<td>34.7%</td>
<td>29.7%</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: Weir, *Survey of Nursing Education in Canada*

The combined figures for the “Unskilled”, "Semi-Skilled" and "Skilled" categories revealed the marked presence of working-class women in the nursing fields. Few daughters of miners, labourers, lumbermen, teamsters or loggers made their way into hospital training programs, but those who did enroll shared a broad working-class heritage with over 30% of students and 20% of graduates. Whether the differential between these latter two totals was a function of a high-drop-out rate among working-class students, or a lesser tendency among working-class graduates to pursue RN status, or the peculiarities of that particular year, was not clear. For working-class and farm women alike, relative familial finances and family ambitions for their daughters and sisters, rather than absolute class status, influenced accessibility to nursing training. Even some "home children" managed the transition from their
Even some "home children" managed the transition from their apprenticeships on Canadian farms to apprenticeships in Canadian hospitals, although as Joy Parr has demonstrated such transitions were often difficult and reserved for "bright, adventurous daughters from prosperous farm families."36

Women from more affluent families chose nursing from a somewhat different set of options. Less than 10% of students communicating with Weir in 1929 claimed professional fathers. Those women had chosen nursing in spite of increased accessibility by the 1920s to professions such as medicine and law, which promised superior financial and social remuneration and required roughly equal years of training.37 In contrast, women from business and clerical backgrounds sought the advantages nursing had to offer in numbers surpassing their peers from working-class families. Like the daughters of the countryside, familial enterprises in business or office work may not have produced obvious economic options for girls, in the same way that connections in industry aided working-class women in securing paid employment.38

Regional economies also served to influence which women entered nursing, although Weir's research methods made drawing firm conclusions impossible. Weir's tally for Quebec's nursing workforce noted a dearth of working-class women, averaging 11.47% percent as compared to 20.46 in Ontario, 26.17 in B.C., 16.91 in the Prairie Provinces, and 24.43 for the Maritimes. This discrepancy may
women in his survey or by the extensive employment opportunities for female workers in Quebec's textile industry. Moreover, the relatively low working-class representation among Weir's Quebec sample, may also have been the result of the unequal language accessibility of his survey. The fact that Weir was unable to administer his intelligence tests in French, and that, while his results were translated from English, the Quebec association informed the CNA that "there is very little demand for the French copy of the Survey Report" brought into question the representation of French-speaking nurses in his sample. The higher returns in the "Business and Clerical and Professional" categories for Quebec may reflect a high occurrence of daughters of that class entering the field, or may be a product of a high return rate from the urban and white-collar English sector. These factors, combined with other large numerical differences between the responses from Quebec nurses as compared with nurses in every other region, raise questions about who in Quebec completed the questionnaire. If the returned forms came primarily from English-speaking nurses in urban centres, then the results reflect the experiences of only a small minority of that province's nurses.

Despite these regional variations the nursing workforce can be characterized nationally. In the first half of the twentieth century, nursing and clerical work joined the already-established teaching profession as the "new" white collar occupations for women at the pinnacle of the sex-segmented labour force. These popular vocations
pinnacle of the sex-segmented labour force. These popular vocations recruited employees from the expanding pool of single, educated white women from all classes, seeking skilled training and labour. To paraphrase the collective words of nurses trained in the interwar years: "In those days, women only had three choices, teaching, secretarial work, and nursing." Of these three, nursing claimed the most elite status. Unlike stenography and teaching, women's predominance in nursing did not require social legitimation (such as the arguments proposed for the superior suitability of women's small deft fingers for typewriters) Demanding a relatively long training period, nursing attracted women from families who could afford to lose the income of their daughters for three years, and who could afford the initial monetary outlay involved in beginning training. At the very least, families had to be able to afford to let their daughters save their pre-training earnings to cover small but significant educational costs. Given the age restriction placed on apprenticeship entrance, aspiring nurses had at least a year between completing public school, and beginning hospital training, in which to accumulate such savings. Discriminatory policies, however informal, prohibited women of colour from acquiring nursing skills. As well, the economic advantages enjoyed by the Canadian-born, and particularly by Canada's "British-stock", facilitated daughters of the native anglo-saxon families gaining access to nursing training. Privileges of race and education did not however obviate the stern reality of nurses' position within the sex-segregated workforce.
Nursing shared with other occupations designated as "female" lower status, prestige, wages and workplace control than their male counterparts. Within nursing itself, however, further segmentation by sub-field divided nurses into three main sub-sectors of health care work, private duty, institutional staff, and public health. Internal segmentation was signified by numerical differential in the distribution of nurses, marked differentiation of economic stability, and consequently, variations in the age and experience each group of nurses possessed. Mobility between sub-sectors and out of the occupation and back to active practice made precise numerical descriptions difficult. The 1931 Census listed 8795 graduate nurses, or 43%, in the "Own Account" category which billed patients directly and therefore were private special duty nurses. Another 9767 nurses were defined by Dominion Bureau of Statistics as "wage-earners" in 1931. Of that group, 5267, were on institutional staffs, and another 4500 were either public health workers, or nurses salaried by doctors, patients or corporations. It is difficult to determine how many of this latter group were employed in the private market. Calculations of gainfully occupied by "Industry" provided numerical indication of the small contingent of women hired to service the industrial workforce. Graduate nurses in pulp and paper manufacturing (22), and in Insurance sector (95) were few in number compared to the 18,852 employed in the "Health" category. Most of the 4500 wage earners who did not work for institutions did not work in industrial nursing. That group would be
divided between the public health and the private duty sector, though in what proportions was not indicated. In any case Census data revealed that over 43% of Canadian nurses worked in the private sector.

An additional insight provided by Census findings pertained to the rural/urban distribution of the nursing workforce. National figures established that, in 1931, 5267, or 26% of the total nursing population, were employed by institutions. Yet Census data indicated that in cities of over 30,000 people only 22.2% of nurses in those urban centres worked in hospitals. Thus, in 1931, cities attracted slightly greater proportions of private duty and public health nurses than did the countryside.

George Weir's figures pertaining to the three main sub-sectors of nursing were less difficult to interpret. Weir's communications with provincial registries led him to conclude that of the 18,174 Registered Nurses across the Dominion, 6370 or 35% worked in Private Duty. Another 7651, or 42.1% were considered by the provincial registrar as currently "inactive" but when actively seeking new positions did so in the private market. Neither Weir nor the registrars hinted at whether these inactive practitioners were sick, on holiday, or employed in non-nursing work, but they did seem confident that over 75% of nurses preferred private duty. Weir's sources estimated far fewer hospital employees amongst their membership than did the Census staff. According to Weir, only
2639 RNs sought post-graduate employment as hospital staff nurses and only 1521 supported themselves with public health work.\textsuperscript{48}

The numerical superiority of the private duty sector was a function of the early twentieth-century system of health services. During and after the First World War, social acceptability of hospitalization accelerated, but patient responsibility for medical costs ensured that the greatest demand for nursing services remained in private care, be it domestic or institutional. For most graduates, private duty was a welcome change from their training years. As one Alberta nurse advised:

> After finishing those three spin-curving, chest-cramping, foot-twinging, memory-testing, ether-scented years of hospital training, it is well for every nurse who dons her candy-box cap to go out into the world to fight her battles alone, to enter the field of private work....\textsuperscript{49}

For private nurses, the variety, choice and independence of one-to-one care captured the essence of what they valued in their working lives. While a case could last several months, others last only a few days. A testimonial from a Victoria nurse suggested her cases averaged less than two weeks each:

> The private duty branch of nursing offers untold opportunities for coming in contact with all that is interesting in the nursing profession....Each of fifty-four cases I have had since graduating two years ago has been of a totally different nature, so that to one
Cases varied in length, location, and activity, according to whether the patient and doctor requested twelve or twenty-four hour attendance for days, weeks or months, to whether the patient was admitted to hospital or treated at home, to whether the family employed other domestic assistance or relied solely upon the nurse, to whether the patient resided in city or countryside, and to whether the illness was chronic, acute, contagious, or psychiatric. Despite allegations as to "the high-handed manner in which [the private nurse] picks and chooses the cases she is disposed to accept," nurses accepted the flexility and variety of assignments, and only a small proportion of nurses, less than 20% nationally, consistently refused certain types of patients or locations.
Source: Weir, *Survey of Nursing Education in Canada*

Twenty-four-hour duty, and country cases were the most frequently rejected, and domestic work was performed by only 55% of Weir's respondents. Where nurses lived influenced their ability to reject certain kinds of tasks. For example, the fact that practitioners in the Prairie provinces accepted country cases and domestic tasks with far greater frequency than did their peers in other regions reflected the vast expanses of rural districts nurses serviced, and the absence of any other domestic assistance in those isolated farm communities.\(^{52}\)
For those nurses, preferring institutional work, special nursing of patients in hospitals offered a variation of private duty nursing which involved the one-to-one care student and staff in institutions rarely encountered. According to Mary Catton of Ottawa's Protestant General Hospital, "Special nursing in a hospital may not be all sunshine and roses, but nevertheless has many favourable features in comparison with private nursing in general in that the nurse gets a certain amount of protection from the hospital." Protection came in the form of fee collection, and Catton believed "the hospital should...assist in securing the payment of bills." Stories such as the following may have won Catton support for her beliefs:

...a recent graduate...spent her first case of three weeks on a farm. At the end of her case the farmer offered her a "fatted calf" in payment of her fee, as an alternative to waiting until the following fall for payment. On the spur of the moment, with the problems of transportation and final disposal of the animal looming ahead, she elected to wait.  

For many, problems negotiating fees did not negate the positive elements of independence and autonomy nurses valued in private work, as a Canadian Nurse bragging session between east and west revealed.

Private nursing in the West is far more satisfactory than in the East, even though [in the West] the nurse's hardships are at times greater and her hours longer. She keeps her
individuality here....She has eight or twelve-hour duty, earns her money, but somehow to me she has not the same spirit of service that is the principle of nursing. She may profit more in a remunerative way, but how much more satisfaction there is in nursing six-year-old Johnny back to health and strength on a prairie ranch in Alberta than taking a tired society debutante to Atlantic City.55

In response, the author of "Nursing in Rural Ontario" assured Canadian Nurse readers that "even in our older settled Ontario, the private nurse has ample scope to exercise her every talent." She did however agree with her western counterpart on the preferential conditions of countryside over cityscape.

It seems to me that rural nursing is far more satisfactory than in the city, even though hours are longer and the hardships greater. A good nurse makes a reputation for herself and retains it -- she has full scope for her own individuality.56

Working in Canada's geographic centre, Manitoba RN Catherine De Nully Fraser spoke for all private practitioners when she emphasized the rewards felt by a job well done. Speaking from her "experience having 'specialed' 140 to 150 patients, many of them in their own homes, where hospital conveniences are lacking," Fraser argued that it was a nurse's privilege to determine the amount of domestic work performed for patients.

Nurses sometimes feel that they are imposed upon, or are expected to do what lies outside their province when nursing in patients' homes....No hard and fast rules and regulations
can be laid down as to the duties of a private nurse. She is more or less free to make her own arrangements with the family and to use her own initiative in a way she cannot do in institutional work. 57

Most nurses agreed that the "personal freedom" inherent in private practice contrasted sharply with the "regimen and disciplines of institutional nursing"58 they had encountered as students.

Yet, once liberated from the strict routine of hospital life, private duty nurses soon discovered a flaw in the unregulated market place; growing public appreciation of the skills nurses offered did not equal increased patient capacity to pay for nursing care. The difficulties making wages cover costs, which many Canadians faced in the economically-instable 1920s, maintained a ceiling on the patient population commanding the resources necessary to purchase skilled attendance.59 And yet, with each new graduating class from Canada's nursing schools more and more nurses vied for those health care dollars which private patients possessed. Having secured employment in this highly competitive market, nurses found it increasingly difficult to resist patient demands to go above and beyond the call of duty, regardless of the stresses placed upon the attendant's own health.60

The 1932 publication of Weir's data merely documented what working nurses had been asserting for some time, that the economic crisis which had beset their occupation had a differential impact on the three main sub-sectors. Income, savings and weeks on duty
varied according to region but consistently placed private duty nurses in the most precarious financial straits. The words of one veteran highlighted the double-edged dilemma confronting nursing's majority: "I am very fond of my work, but consider the irregularity and long hours impair my health." As Figures 3.12 through 3.15 reveal, private duty nurses had trouble getting enough weeks of work to keep them financially solvent, whereas hospital and public health positions guaranteed constant employment. Averaging less than 30 weeks on duty for 12 months in 1929 and early 1930, Weir's private duty participants booked off for fewer weeks of vacation than did their peers in public health or institutional work, and sat idle for over three months. Equally dramatic was the differential between the amount of illness reported by private duty nurses and that experienced by their peers.61
Figure 3.12

Average Time Spent
Private Duty Nurses, 1929-1936

- 3.3 Weeks Vacation
- 4.5 Weeks Ill
- 14.3 weeks unemployed
- 29.9 Weeks On Duty
Figure 3.13
Average Time Spent
Institutional Nurses, 1929-1930

- Illness: 0.8 weeks
- On Vacation: 4.2 weeks
- On Duty: 46.3 weeks
- Unemployed: 0.7 weeks

Figure 3.14
Average Time Spent
Public Health Nurses, 1929-1930

- On Vacation: 4.0 weeks
- Illness: 0.9 weeks
- On Duty: 47.1 weeks
With "far too much time spent 'waiting' for cases," even the healthiest of graduate nurses had financial difficulties. Of those consulted by Weir, only half had earned enough in 1929-1930 to just pay their bills, and the median gross income for the group was $1022.

Private Duty Nurses  $1022
Institutional Nurses  $1385
Public Health Nurses  $1574
Superintendents   $2004

Source: Weir, *Survey of Nursing Education in Canada*
Hospital and public health nurses earned substantially greater annual incomes, grossing $1385 and $1574 respectively, while superintendents reported $2004. The nation-wide economic advantages enjoyed by hospital staffs, were more than matched by public health salaries in all regions.

Figure 3.17
Annual Income, by Province, 1929-1930

Median Annual Gross Income, 1930
Superintendents, Staff Nurses, and Private Duty

Source: Weir, Survey of Nursing Education in Canada

Weir's gross figures included the value of board and room, which most institutions and many organizations provided. The amount of cash nurses actually received equalled Weir's gross figures less the value of food and lodging at the various work sites. However, private duty nurses arranged for their own accommodation, which
they had to maintain even when lodging temporarily at a patient's residence. Having to pay rent substantially raised the cost of living for private duty nurses over their peers "living in".63

Cost of private accommodation varied. The "typical budgets of the average private duty nurse" prepared by Weir differentiated between his version of "Nurse A", whose familial support saved her from being "entirely dependent on her earnings to provide for the future," and the self-supporting prototype, "Nurse B". As Figure 3.18 displays, the former required nearly $1400 to cover her expenses, while the latter had to earn $1600 per year.
Rent and Board
Clothing
Uniforms
Laundry
Fees
Car Fare
Insurance
Charity
Recreation
Dentist
Dry Cleaning, etc.
Health, Beauty Parlor, etc
Presents, Gratuities and Subscriptions
Sundries
Holidays
Total

Nurse "A" $325.00
444.00
250.00
60.85
105.00
21.00
45.60
166.30
60.00
60.00
43.00
12.00
12.00
75.00
30.00
120.00
$1386.15

Nurse "B" 444.00
300.00
91.05
144.00
21.00
45.60
132.00
60.00
60.00
40.00
36.00
36.00
75.00
40.00
100.00
$1590.65

"This includes two pair of shoes, white polish, six blouses, three skirts, eight aprons, eight bibs, six pair cuffs, six collars, eight pair stockings, three caps, and misc repairs to uniforms."

Source: Weir, Survey of Nursing Education in Canada

Living at home was the only way many nurses could financially survive in the private sphere, and at the same time nurses in all sub-
fields faced responsibilities for "family or personal obligations which consumed their last dollar above bare living expenses." Whether falling into Weir's categories of A or B, most private nurses averaged well below the standard of living Weir deemed necessary for them to remain "a member, and probably a leader in the community."

Weir's consternation over nurses' community status revealed the deeper meaning signified by unemployment and wages. Nurses were supposed to be economically self-sufficient; nursing was supposed to offer a viable economic option to marriage. Thus even though they earned more than women working in other white collar occupations, the precarious financial conditions nurses faced jeopardized the ideal of economic and social independence for women. Comparisons with annual incomes of clerical workers, for example, indicated nurses' superior earning power even during a period of high unemployment. Figure 3.19 lists wages paid workers at the Bank of Nova Scotia and Manufacturers Life Insurance Company Toronto head offices.
Even though nurses as a group fared well compared to Toronto's clerical workers, both groups were struggling to make ends meet. For those who hoped the "new day" had arrived, nurses experiences confirmed their worst fears. If nursing, an occupation privileged by relatively long period of institutional apprenticeship, could not offer women financial stability over their lifetimes then the entire concept of women's economic independence was called into question.

The disparity between annual income and cost of living, and what that disparity meant for women workers, was manifest in the relative abilities of nurses to save for the future. Approximately half of private duty and half of the hospital nurses had saved nothing from their year's labour. Of private duty practitioners, 40% saved $240 on average over the year, as compared to $314 averaged by 45% of institutional nurses, and $400 averaged by 40% of public duty nurses. In a reprint from the Federation of Women Teachers'
Association of Canada Bulletin. Flora Stewart pointed to the common dilemma facing many working women.

Sad to relate, the basis of remuneration still rests in masculine hands, with the result that the average professional and business woman has none too large a margin between necessary expenditure and income. Having chosen a career...the thrills of independence in youth, the delightful freedom which independence brings in middle age, carry in their train the dire necessity of independence in old age.69

Financial advice such as that offered by Kathleen Snowdon, Thrift Advisor for the T. Eaton Company, appeared periodically in nursing publications and optimistically declared that "haphazard, thoughtless spending is certain to deprive us of much that the same income well administered would provide."70 Wise budgeting alone, however, could not prevent the disillusionment that many graduates experienced as their income failed to stabilize after several years. As a 1926 Canadian Nurse reprint of an American Journal of Nursing article confessed:

When you have come to the end of three financially lean years in a school for nurses and find yourself a full-fledged nurse, privileged to write R.N. after your name, and have temporarily placed in your pocketbook the cheque for your first case, you are entitled to feel, for a few days at least, that you are in the near-millionaire class. Perhaps the cheque is for $168, for it was a four-week case. Oh Girl! What a delirious time you will have spending those dollars for-
things you were forced to do without when your hospital allowance was $10 a month.  

Enthusiasm for the financial independence that paycheques represented wore thin as the memories of student life began to fade.

But perhaps you have been writing R.N. after your name for some time, possibly for several years, and have grown accustomed to fairly frequently pocketing cheques of three figures and yet for some reason or other your bank account fluctuates sadly....You have learned, too, that your income is not as magnificent as you thought it would be until you discovered that you cannot be on duty every day in the year...There are forced periods of waiting....

The inability of private duty or institutional sectors to implement a system of experience-based pay increments, made cumulated savings a rarity. The opinion of the average public health nurse "that she is 10 per cent better off financially than when she first began her career nearly 9 years earlier" was shared by very few private duty or institutional nurses.

Only 3% of the public health respondents had saved nothing over their careers, whereas 47% of hospital and 54% of private duty nurses showed no career savings, and the remainder claimed a surplus of less than $600. For the 46% of private practitioners who claimed a surplus, the average was less than $600. Even the superintendents Weir consulted, who as a group saved a median figure of $2078 since embarking on their careers, worried about their economic future for savings could only stretch so far if
unemployment or sickness struck. The solution for many lay in insurance and annuities, which would, in the opinion of one veteran private duty practitioner "help [nurses] remove from their lives that sordid financial anxiety which must sap peace and pleasure from their existence." Over 50% of private duty nurses owned one or the other, as did 58% of superintendents, 68% of hospital employees and 80% of public health workers.

Unfortunately, annual payments into insurance or pension plans, however judicious for the long term, once purchased were hard to maintain. Lamenting the lack of "financial protection" of many private duty nurses, Weir concluded:

Were their health to give out at any time, or when they become too old to work -- and the life of a nurse is especially hard and exacting after the average woman reaches about 50 years of age -- there appears no alternative but economic ruin.

Other commentators agreed with Weir that the threat of disease intensified nurses' economic perils. In a polemic endorsing superannuation M. Judson Eaton argued in the Canadian Nurse:

In almost every other occupation the fact is recognized that it is impossible for people to work seven days in the week - not to mention twelve hours out of twenty four....Not so with the nurse. Every day's rest or recreation she takes represents a loss greater than any gain possible on a day "on duty". She may, and often does, work overtime and risks her own health recklessly when the life or welfare of
her patient is at stake, and when, after the battle is won, she is obliged to spend a week, a month - or sometimes longer - recuperating from the effects of the strain....\(^7\)

In a similar vein, Montreal private nurse Agnes Jamieson utilized her position on the CNA Publication Committee to condemn the extreme length of nurses' working days. Jamieson called for the abolition of twenty-four-hour duty, and the exploitation of nurses that around-the-clock attendance involved: "if patients are not sick enough to have [and hire] night nurses they are well enough to stay alone...." wrote Jamieson. Even twelve-hour shifts -- "actually fourteen hours from the time [the nurse's] alarm goes off in the morning until she arrives home at night, weary and ready for bed" -- were debilitating when worked consecutively.\(^7\) Despite efforts to the contrary, throughout the 1920s and 1930s these hours continued to prevail in domestic and special duty service, and private nurses faced double indemnity: they needed steady work to exist, but steady work undermined their health and threatened their ability to work steadily.

Institutional nursing promised more reliable volume and hours of work, and thus more reliable income, but no real relief from long shifts. Graduate nurses were all too familiar with the day-duty/night-duty schedule which had run their lives during training. Investigations into the alarming rate with which nurses appeared among the clientele of tuberculosis sanatoriums suggested that hospital work of any kind, student or staff, might be dangerous. In
her article "Increase of Tuberculosis Among Nurses", the Lady Superintendent of the Queen Alexandra Sanatorium in London Ontario, Ann M. Forrest, pointed out the bitter irony of tuberculosis increasing "among one of the valuable groups of workers in the campaign for better health." Citing a study of thirteen Canadian tuberculosis facilities, with 1514 women in residence, 99, or over 6% were nurses. "As many nurses were under treatment as school teachers, stenographers and university women taken together."80 Another study of 60 nurses admitted to Manitoba's Ninette Sanatorium, discovered that 40 had developed symptoms during their hospital training, and 8 of the other 10 diagnosed within the first year of graduate practice had remained on as hospital staff nurses.81 Thus Weir's data describing the relative health of the institutional and public health sectors vis à vis private work may have masked the frequency with which nurses unable to withstand the rigours of steady hospital employment pursued their vocation in the more flexible private duty market. However, this option could only be exercised for the short term, for in the long-term economic exigencies demanded that steady employment be essential.82

Differences in regularity of employment, income, savings and health which distinguished private practice from hospital employment and even more dramatically from public health or administrative work were accompanied by further differences in the age and experience of the women in each sector. For example, the relative ease with which nurses in each type of work could support
themselves throughout their careers determined the concentration of nurses over age 50 in each sub-sector. Of the 7% of Weir's private duty respondents who were more than 50 years old, only 1.13% were over 60 years, and .17 over aged 65. Hospital staff respondents tended to be even younger, with only 5% over age 50, though 1.27% were over age 60 and .23 more than 65. The most recently established of the three sub-sectors, public health, supported a relatively old group of nurses with over 10% more than 50 years old, but very few had surpassed 60 years. Superintendents were older still, and the fact that nearly 20% of those included in Weir's study were employed after their 50th birthday served as mute testimony to the career potential realized within the administrative sector.83

The differences in age and experience, indicated by the relative concentration nurses in the over-50 age bracket, was accentuated when measured in terms of median age and experience. Figure 3:20 lists Weir's data for the median ages of superintendent, public health, and hospital staff nurses. For the latter two sub-sectors, the median age was 31 years. Institutional employees were more evenly distributed over the various age categories, the middle 50% falling between the ages of 26 and 39, whereas private practitioners were more highly concentrated, with 50% falling between 26 and 33.84.
Figure 3.20
Ages of Nurses by sub-sector, by province, 1929-30

<table>
<thead>
<tr>
<th>Superintendents</th>
<th>Staff</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>30.8</td>
<td>37.7</td>
</tr>
<tr>
<td>Prairie Provinces</td>
<td>29.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Ontario</td>
<td>32.1</td>
<td>38.8</td>
</tr>
<tr>
<td>Quebec</td>
<td>33.7</td>
<td>33.4</td>
</tr>
<tr>
<td>Maritime Provinces</td>
<td>31.8</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Weir, *Survey of Nursing Education in Canada*

The comparative youth of the private group was reflected in terms of experience. Of the 1765 private duty nurses whose responses Weir could tabulate, the median number of years experience was 5.8 years, as compared to 5.7 for the nearly 1000 respondents from the institutional sector.85 Public health positions required at least six months post-graduate training, and only those new graduates with financial capabilities and a passion for public health work pursued these positions immediately. Most, over 70% of public health nurses, worked for more than a year in private duty and institutional work before pursuing their public health careers.86
**Figure 3.21**

*Work Experience of Public Health Nurses, Canada, 1929-1930*

<table>
<thead>
<tr>
<th>Region</th>
<th>Years in Private Duty</th>
<th>Years in Institutional Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Prairie Provinces</td>
<td>1.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Ontario</td>
<td>2.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Quebec</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Maritime Provinces</td>
<td>2.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Canada*</td>
<td>2.0</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Source: Weir, *Survey of Nursing Education in Canada*

Even public health nurses, defined by a median age of 37.4 years and 8.8 year experience, were, like their peers on hospital staffs and in private practice, predominantly graduates of the 1920s.87

Not so with superintendents. Only 26% of the 150 administrators Weir contacted had graduated since 1920. Over two-thirds had completed their training before the end of World War I and in 1929 recorded on average 14.5 years work experience. Thus the 8-13 year age gap between administrators and the graduate nurses working in hospitals either as staff nurses or as specials signified substantially different generational experiences.88

Several factors may have reinforced the age and experience differential. First, by the 1920s most hospital expansion had ceased, so that the opportunities for promotion were limited to the second generation nurses who had gained valuable supervisory
experience during the earlier decades of growth. Women like Grace Fairley, Kathleen Ellis, Ethel Johns, Christina MacLeod and Mabel Gray launched in the 1910s successful administrative careers which spanned the interwar decades. A second possible factor was movement within the occupation. Most new graduates entered active practice providing one-to-one care to individual patients. As financial difficulties mounted, many private duty nurses tried to improve their lot by shifting into one of the more stable areas of employment. Of the more than 50% of institutional nurses who cited having experience in other sectors of the occupation, 89% had worked as private duty nurses for an average of 1.3 years. Only 11 per cent had transferred from public health employ. Conversely, nearly all 660 public health nurses reporting to Weir claimed previous experience in private duty or hospital work, ranging in length from 1.8 to 2.9 years.

Weir's data verified that many nurses had already moved out of the private market, and many others planned to follow suit. Of those actively practicing only 55% of private nurses were satisfied with their branch of the profession, as compared to 71% of institutional nurses and 87% of public health workers. Relatively few, 14%, 8% and 11.4% respectively, were determined to leave their particular sectors. Figure 3.22 shows the anticipated destination of those nurses.
Many private nurses were sadly disappointed in the "material satisfactions" their work incurred, and the limited opportunities for "leisure"—that uncertain employment caused, but most of those dissatisfied with their lot were unsure of how to improve it. More than one-third of the private duty group were undecided as to their future plans, and pondered whether to continue doing the work they preferred, or to seek out employment, nursing or otherwise, which would improve their financial status.

Many chose this latter route, making out-migration from the occupation a third factor influencing the distribution of age and experience. Lacking the job security and avenues for advancement which public health and administrative postings promised, private duty and hospital staff positions appeared to many nurses less attractive than other jobs, or marriage. Claimed one woman, "I intend to remain in private duty nursing unless I find an ideal husband."
Census figures for 1931 and 1941 suggested the frequency with which nurses left active practice. For example, for all of Canada the size of the student-nurse population remained fairly constant over the 1931 to 1941 period, being listed at 11,436 to 11,822 nurses-in-training respectively.\(^{93}\) Weir's numbers for 1931 were comparable. Yet if 11,436 students were enrolled in nursing schools in 1931, then by 1934, when all the potential graduates would have been added to the active nursing population, 31,898 graduate nurses should have been in the workforce in 1934 alone, with the graduating classes of 1935 through 1940 swelling the ranks each year. The fact that by 1941 the workforce only measured 26,887 indicates the substantial outmigration from active practice, either through retirement, marriage, occupational change or death.\(^{94}\)

Dominion Bureau of Statistics data did not indicate if any particular sub-sector was affected more than another. However, qualitative data revealed what quantitative data did not. By the time Weir began his nationwide tour, economic strain was forcing many private nurses to consider seriously the occupational options they had earlier rejected.

I enjoy my work very much but I would not advise any one else to join the profession on account of uncertain employment - not enough leisure and unprofitable in
comparison with other professions, e.g. stenography, teaching.

If there was anything other than nursing that I knew how to do, I think I would do that.\textsuperscript{95}

The nurses Weir consulted, and many more, acted on their dissatisfaction, and left the occupation, seeking waged-labour in other occupations, or taking on the non-waged responsibilities marriage entailed.

For those who remained, easy solutions were not found. The "emergency" situation of the early thirties continued throughout most of the decade, and it was not until the onset of World War II that the nurses' employment situation was dramatically reduced. When the Dominion Bureau of Statistics sent forth its troops in 1941, the documentation produced described a very different set of working conditions than they had encountered ten years before. After 20 years of economic instability, Canadian nurses had abandoned private duty work, placing their collective fate in the centralized, institutional model of health services. In 1931, 4614 graduate nurses, or 22.5\% of the nursing workforce, were employed in Canada's 693 hospitals and 59 asylums. By the end of that decade 38\% of the nursing workforce were on institutional payrolls, and received their paycheques from institutions.\textsuperscript{96} The shift from private duty to hospital employment reported in the 1941 \textit{Census} was substantiated in a 1947 Canadian Nurses Association statement to the Dominion Council of Health.\textsuperscript{97}
Figure 3.23

Distribution of Nurses by Sub-sector, 1930, 1943

<table>
<thead>
<tr>
<th>Year</th>
<th>1930</th>
<th>1943</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses in private practice</td>
<td>6370</td>
<td>6387</td>
</tr>
<tr>
<td>Nurses in hospitals and public health work</td>
<td>4160</td>
<td>13,959</td>
</tr>
</tbody>
</table>

Source: CNA, "Report to Dominion Council of Health", 1947

By the last years of World War II, the percentage of nurses working in private market had dropped from over 60% in 1930 to only 31.4% in 1943, a trend which would accelerate in the post-war decades.

In 1948, celebrating the ascendance of hospital employment, the Manitoba Association of Registered Nurses waxed eloquent over the emergence of nursing as a "public utility needed by all and not just a luxury service for those financially able to pay for individual care." Inspired by allied victory of World War II MARN reminded its members that "gone are the days of quiet, individual pursuit in nursing service" and encouraged them to "grasp (mentally and physically - with heart and hand) every opportunity to participate in the social planning for the betterment of humanity." Such a transition improved the economic lot of many nurses, but hospital employment could not match the control over work -- the choice, variety and independence -- which private duty offered.
By the 1940s, a new model of health services was emerging, one in which the state agreed to pay for medical and nursing attendance, but only if such attendance occurred within the hierarchy of control, in which nurses took their skilled, but subordinate, place. Nursing's economic crisis of the 1920s which had sparked the Weir Survey, and the subsequent depression of the 1930s, guaranteed for the architects of the new health services model a ready workforce of skilled attendants. The workforce to which they turned were those members of the female labour market who were privileged by age, education, race and nativity. By the end of World War I, the rapid growth in the number of nurses had stabilized, although the number of nurses per Canadian continued to increase throughout the 1920s. As that decade progressed unemployment among nurses reached crisis proportions, a condition exacerbated by the more generalized depression of the 1930s. The largest sub-sector was the hardest hit. Private duty nurses experienced long periods of unemployment and growing feelings of disillusionment. The resulting outmigration from that sector and from the occupation may have accentuated the generational difference separating superintendents from private duty and staff nurses. Certainly, the third generation of trained nurses shared a common set of economic circumstances which structured their work experiences and options. Commissioned investigators such as George Weir agreed with other commentators speaking through the pages of the *Canadian Nurse* in their assessments of the financial difficulties
facing the new generation of Canadian nurses. Equality, recently won on the political front, appeared as elusive as ever on the economic battlefield.
Notes

1 In her autobiographical contribution to Margaret Gillett and Kay Sibbald's collection of essays on women at McGill University, Eileen C. Flanagan attributed her decision to become a nurse to the positive image of nursing following World War I: "Owing to the war, there was a great interest in nursing...." Eileen Flanagan, "The Parts of Pisces" in Margaret Gillett and Kay Sibbald, eds., A Fair Shake: Autobiographical Essays by McGill Women (Montreal: Eden Press, 1984), p. 42.

2 Patient frustration with nursing costs was part of the larger dilemma facing Canadians, that of rising health care expectations (encouraged by the promises of "scientific medicine") with no concomitant increase in the ability to pay for services. Participants in the Canadian Nurses' Association Survey responded to investigator George Weir's question---"Which was to you the more difficult problem - to pay for the nursing care or to get the right kind of nurse?"---that paying for nursing services was 30% more difficult for hospital patients and 20% more difficult for home patients, than was hiring an attendant with a suitable disposition. George M. Weir, Survey of Nursing Education in Canada (Toronto: University of Toronto Press, 1932), p. 402. The medical profession's complaints with nurses were somewhat more confused. Ontario private duty nurse Edith Gaskell pointed out the contradictions of medical opinion in her reply to Dr. Mayo's accusations that nurses had commercialized their services. "Nurses are Not Selfish or Overpaid. Toronto Nurse's Reply to Dr. Mayo", Toronto Star Weekly, October 29, 1921. Reprinted in Canadian Nurse, pp. 25-26. In part this discussion stemmed from a growing interest in state welfare policies. For example, in the 1920s the Dominion Bureau of Statistics began collecting statistical information pertaining to social welfare issues. Thus the 1931 Census states "the statistics of institutions are a part of the general body of statistics having a predominantly social implication....On an annual basis, as it is hoped eventually to place them in Canada, and with subsidiary statistics on the extramural operations of various social and welfare organizations, they will present a body of data of increasing value to the students of social problems in the modern State." Census, 1931,

3 Gaskell, Canadian Nurse, 1921, p. 26..


5 For example, F. Eaton, Report of the Advisory Committee on Labour Conditions in Hospitals (Victoria: King's Printers, 1938).

6 E. Macpherson Dickson, "Report on the Survey of the Field of Nurse Training", Registered Nurses Association of Ontario, 1924 (RNAO Library). Dickson's investigation "for the purpose of procuring "authentic information on the hospital life and training of the nurse" was inspired by the desire to standardize nurse training at the 90 schools of nursing in Ontario. Dickson acknowledged that given the number of schools, and the limited financial and personnel resources of the RNAO only a sample of all the schools could be inspected.

7 Ibid. For example, on p. 32 Eaton listed nurses' salaries paid at 53 British Columbian hospitals, "1 hospital at $30.00 plus maintenance. 1 hospital at $40.00 plus maintenance. 5 hospitals at $45.00 plus maintenance..." etc. Her discussion of nurses' opinions was equally general. "Without doubt, the nurses believe that regulation of wages is second in importance to regulation of hours of work." Eaton seems to have followed a popular style when reporting her findings. Dickson's 1924 "Report on the Survey of the Field of Nurses Training" p. 12, utilized a similar method of listing her data.
8 Dominion Bureau of Statistics (DBS), *Census of Canada* 1921, 1931, 1941 (Ottawa: King's Printer, 1929, 1936, 1946); George M. Weir, *Survey of Nursing Education in Canada*.

9 DBS, *Canadian Hospital Directory* 1929, 1933, 1934, 1935, 1939 (Ottawa: King's Printer) was an occasional publication of the Dominion Bureau, based on information gathered for the Diennial Census and on data collected during Intercensal years by the Canadian Hospital Association.


11 The Joint Study Committee, composed of representatives from the Canadian Nurses' Association and the Canadian Medical Association was struck in 1927. WGHAA Annual 1932 (WGHAA Archives): p. 16; also Weir, *Survey of Nursing Education in Canada*.

12 CNA, Minutes, 1922, (National Archives).


14 The changing nature of the occupation itself makes drawing firm conclusions about the size of the nursing workforce difficult. For example, the 1891 *Census* categorized nurses together with midwives. The next *Census* in 1901 listed nurses separately, thus the great reduction in the number within the nurse category. Neither that *Census* nor the 1911 report mentioned student nurses at all, and it is unclear whether the 1911 figure of 5476 nurses included nurses-in-training.

15 DBS, *Census*, 1931, 1941.

16 Weir did not speculate on how many graduate nurses who were not eligible for registration -- that is, did not graduate from training programs approved by the provincial nursing associations -- were also practicing. Weir, *Survey of Nursing Education in Canada*.
17 Ibid.

18 Marta Danylewycz, Taking The Veil: An Alternative to Marriage, Motherhood, and Spinsterhood in Quebec, 1840-1920 (Toronto: McClelland and Stewart, 1987). Danylewycz claims that until the early twentieth century, "Nursing had yet to shed its stigma as a menial task for untrained hospital attendants," and thus women entering orders such as the Sisters of Misericorde experienced a decline in their social status. Efforts to counter this image of nursing amongst French Canadian women resulted in the publication of two French nursing journals, La Veilleuse in 1924, followed by La Garde-Malade canadienne-française in 1928. The latter was founded by Miss Charlotte Tassé, 1917 graduate of Notre-Dame Hospital, and from 1919, director of nursing and nursing education at the Albert Prévost Sanitarium. Tassé was one of the new generation of lay nurses appointed to administrative positions in Quebec hospitals. Edouard Desjardins, Heritage: History of the Nursing Profession in Quebec from the Augustinians and Jeanne Mance to Medicare (The Association of Nurses of the Province of Quebec, 1971), p. 159, 160, 184. In 1931, the Census report explained that only religious workers with no special training would fall under the more general category of "Nuns and Brothers, n.e.s", not elsewhere stated. Nuns with particular education or skills were listed under the relevant occupational heading.

19 DBS, Census, 1931, 7, Table 9. By 1931 nuns were reporting their occupations more specifically, and thus the DBS noted that "In 1931 a larger proportion of nuns were reported with these occupations [teaching, nursing etc.] than in 1921." (p. 28).


21 Calculated from Connelly, Last Hired, First Fired, p. 93.

22 Lowe, Women in the Administrative Revolution, especially Chapter 3.
23 See K. McPherson "Nurses and Nursing in Early Twentieth Century Halifax, 1900-1925" (M.A. thesis, Dalhousie University, 1982) for a discussion of the differential status accorded the few male students in the pre World War I years at Halifax's Victoria General Hospital. During the interwar years male practitioners did not participate in provincial association activities, nor did they make their way into hospital training school records, or alumnae documents. See VGHAA, Minutes 1920-1940 (VGHAA Archives), WGHAA Journal/Annual 1900-1950 (WGHAA Archives).


26 This point was made clear to me by a number of female interview participants, and one husband who, during an interview with his wife, volunteered the information that he expected her to stop working after their wedding. She did stop working regularly for pay, but clearly enjoyed her occasional terms substituting for absent nurses at the local Red Cross Hospital, Genesta McMullan, interview by author, Hansport, Nova Scotia, April, 1982. Reminiscences collected by the WGH Class of 1928 include several stories of women returning to nursing when marital finances necessitated, Mary Shepherd, ed., "The 1928 Class: 28 Years Later, 1956" (WGHAA). The same claim was made for British Columbia by F. Eaton in Report of the Advisory Committee, p. 7. "In most sections of the province it
is possible to secure temporary and part time help in the immediate district for the reason that graduate nurses, married and resident are often available for temporary work."

27 DBS, Census, 1931.


29 Black women were not accepted into Halifax's Victoria General Hospital until after World War II, according to Mrs. Oliver, interview by author, Lower Sackville Nova Scotia, 1981. This claim was substantiated by one of the interview participants in the videotape, Black Mother, Black Daughter (Canada: National Film Board, 1989). For the details of the long-running debate regarding the admission of Chinese and Japanese women to the Vancouver General Hospital nursing program see, Vancouver General Hospital Alumnae Association, Minutes, 1908, May 1910, May 1917, 1932 (VGHAA Archives). During the World War II evacuation and internment of British Columbia's Japanese citizens, Japanese women enrolled at the VGH were not allowed to continue their training. Harriet Pentland, interview by author, Tape Recording, Winnipeg, Manitoba, 13 June, 1986. "Lene Desjarlais" In Speaking Together: Canada's Native Women (Toronto: Hunter Rose, 1975), p. 46. tells of her first day at Brandon General Hospital. Even when federal grants broke down the financial barriers which kept women like Desjarlais out of higher education programs experiences such as hers represented other barriers. "I heard someone say that I'd be just like the rest of the Indians and quit, wasting the government's money."

30 Weir, Survey of Nursing Education in Canada, p. 69, 97.

31 DBS, Census, 1931, 1941.

Pitman, Ltd., 1988) Chapter 1, "Growing Up Female" for a discussion of girls' increased educational opportunities at the public school level during the interwar years.

33 Ibid. See Chapter 4 for a discussion of formal entrance requirements.


35 For a discussion of the importance of women's labour to farms in the prairie west see, Sara Brooks Sundberg, "Farm Women on the Canadian Prairie Frontier: The Helpmate Image," in Strong-Boag and Fellman, Rethinking Canada: The Promise of Women's History (Toronto: Copp Clark Pitman, 1987).


38 For a discussion of the importance of family and kinship ties for Quebecois women seeking work in the textile mills of Quebec and New England see, Gail Cuthbert Brandt "Weaving It Together: Life Cycle and the Industrial Experience of Female Cotton Workers in Quebec, 1910-1950", Labour/Le Travailleur, 7 (Spring, 1981): pp 113-126; and Joy Parr, "Rethinking Work and Kinship in a Canadian

39 The question remains as to the accessibility of the survey questionnaires to French-speaking Registered Nurses. Of the 2280 sent out to Quebec nurses, only 764 questionnaires were returned completed (33% as compared to 34% in Ontario, 46% in the Maritime Provinces, 59% from the Prairie Provinces, and 64% from BC). In 1930 Weir wrote to the Quebec Association stating that to date "not many of the questionnaires issued in this province relative to the Canadian Nurses Association Nursing survey had been returned completed". Once published the Quebec association found there was little demand for the Survey. Weir, Survey of Nursing Education in Canada.

40 For example, Quebec nurses claimed they refused "country cases" far more than nurses elsewhere, Ibid pp. 88-89:

41 Clearly, other options existed for women, but the concensus among retired nurses interviewed was that "blue collar" occupations were no more a choice than were the professions. See Chapter 4 for further discussion of women's occupational options in a particular regional economy.


43 Joy Parr, Labouring Children, p. 129, cites conflicts between Canadian families and their "adopted" daughters from the Barnardo agency over releasing trust fund money so that the young women could pursue nursing training.

44 DBS, Census, 1931.

45 Ibid. The Census report also revealed that nearly one-half of graduate nurses lived and worked in the two cities of Montreal and Toronto.
46 Weir stated that "inactive nurses are largely married women or those who have, temporarily at least, entered other professions or occupations. These nurses ensure their eligibility to nurse, should the occasion arise, and to derive any actual or potential advantages of registration, by payment of the prescribed fee. The great majority of inactive nurses would, if active, come within the category of Private Duty Nurse." Weir, Survey of Nursing Education in Canada, p. 56.

47 Ibid. Weir considered his numbers "approximate estimates" at best. "As a matter of fact, nurses change so frequently from one classification to the other, that no data, however mathematically refined, can lay claim to more than very temporary accuracy."

48 Ibid. p. 55.


53 Mary Catton, "Special Nursing in the Hospital", Canadian Nurse, pp. 293, 291.
54 Ibid.

55 Lucy Hatch, "Private Nursing in Alberta" p. 201.


58 Weir, Survey of Nursing Education in Canada, p. 80. Also public health nurses thought that hospital schedules were "too regular".

59 John Herd Thompson and Allen Seager emphasize the instability of the Canadian economy during the 1920s, as it varied over time and region, and contrast that reality with the image of the "Roaring 20s" often borrowed from American literature. John Herd Thompson with Allen Seager, Canada 1922-1939: Decades of Discord (Toronto: McClelland and Stewart, 1985), pp. 76-103 and 330.

60 "A resident nurse on a case charges forty cents an hour for a fifteen-hour day, but if the patient's condition is critical and her services are required for a longer period, she gives that time gratuitously. This means that the nurse who is the only nurse on a private case in a home, and is entitled to have, out of every twenty-four hours, six hours undisturbed reset and three hours' recreation, far too frequently gets neither." Edith Gaskell, "Nurses are Not Selfish or Overpaid," pp. 25-26.

61 Unemployment or extended illness may have cost some nurses their positions within institutions or organizations, and pushed them into the private market thus raising those variables amongst private duty nurses.

62 Weir, Survey of Nursing Education in Canada, pp. 75-77.

63 Ibid, p. 76-77.

64 Ibid., pp. 76, 103. Agnes Jamieson claimed in the April 1928 article to the Canadian Nurse that "Over half of private duty nurses

65 Weir, Survey of Nursing Education in Canada, p. 79 for his typical budgets. To verify his figures Weir provided a comparative budget for a "professional woman engaged in a library."

66 These figures are for employees at the Bank of Nova Scotia, Ontario branches and head office and Manufacturers Life Insurance Company Toronto head office. Lowe includes figures for junior clerks and stenographers "those employees with less than one year of service", and those figures are somewhat lower than that for employees with more than one year of service, which I have cited here. See Lowe, Women in the Administrative Revolution, pp. 154-55.


68 Weir, Survey of Nursing Education in Canada, pp. 75, 124-25, 102-103.


72 Ibid. Charlton admitted that budgetting alone would not ensure that incomes would be sufficient, but considered it important nonetheless that a budget would "help to determine what you need most, and it may, and undoubtedly will, give you a certain peace of mind because you will know you have done your best with the materials at your command."
73 Weir proposed a salary schedule for institutional nurses which would rectify the absence of any "system of annual increments" in hospital work. Initial salaries in the Weir scheme started general floor duty nurses at $85 and specialists, who had taken an additional year of training, at $100. Within five or ten years these nurses were expected to reach the terminal salary of $125 and $150 respectively. He offered his CNA benefactresses no suggestions as to further remuneration for more experienced nurses such as the WGH's Margaret McGillvray who served as night superintendent for nearly 20 years. Weir, Survey of Nursing Education in Canada, p. 107.

74 Ibid, p. 125.


76 Edith Gaskell, "Annuities", Canadian Nurse, p. 564. In a report of the CNA Private Duty Section; a committee charged with investigating insurance plans discovered that arranging for group insurance was impossible, "as many companies refuse to consider insurance at all on female lives. Some companies that granted accident and health insurance to women, up to three months ago, now refuse to do so. Individual policies can, however, be secured in some good reliable companies...." Canadian Nurse, p. 352. See also Stewart, "How Life Insurance Benefits Business and Professional Women".

77 Weir, Survey of Nursing Education in Canada, pp. 76.


79 Agnes Jamieson, "Problems of the Private Duty Nurse."


81 Ibid.

82 Limited numerical evidence makes the assessment of changing health standards of nurses a difficult task. Hospital officials'
concerns about student health were not new to the interwar years, but during those decades health issues received substantially more attention. For example, in 1932 Superintendent of the Vancouver General Hospital, Dr. Haywood stressed that the question of tuberculosis among nurses "is not a problem peculiar to this hospital, but has been receiving the attention of hospital authorities and medical authorities the world over," VGH Annual Report, 1932. Eaton, Report of the Advisory Committee on Labour Conditions in Hospitals has several sections on the health of nurses in B.C. hospital. Blanche Pfefferkorn, A Study of the Incidence and Costs of Illness Among Nurses (Joint Committee on the Costs of Nursing Service and Nursing Education of the American Hospital Association, National League of Nursing Education; American Nurses' Association, 1939) addressed the problem in the American context.

83 Weir, Survey of Nursing Education in Canada, pp. 69, 97, 118, 145.

84 Ibid, p. 69.

85 Ibid, p. 100.

86 Ibid, p. 123. Weir discovered that "practically all the public health nurses of Canada have had some experience, however brief, either in institutional or private duty nursing. In the care of 27.5 per cent. of the public health personnel, this experience in other branches of the profession was under one year."

87 Ibid, p. 122.

88 Ibid, p. 149.

89 For an analysis of their role in influencing the direction of Canadian nursing see, Margaret May Allemand, "Nursing Education in the United States and Canada, 1873-1950: Leading Figures, Forces, Views in Education," (Ph. D. diss., University of Washington, 1974.)

90 Weir, Survey of Nursing Education in Canada, p. 100-101, 123.

91 Ibid p. 81.

92 Ibid p. 68.
93 A very small portion of this increase is attributed to the emergence of university schools of nursing, which graduated 1493 students between their establishment in the post-WWI years and 1940. *Historical Statistics*, Series 439-55. "Full-time university undergraduate enrolment, by field of specialization and sex, Canada, selected years, 1861-1975."

<table>
<thead>
<tr>
<th>YEAR</th>
<th># Grads. University Nursing Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>122</td>
</tr>
<tr>
<td>1925</td>
<td>188</td>
</tr>
<tr>
<td>1930</td>
<td>301</td>
</tr>
<tr>
<td>1935</td>
<td>372</td>
</tr>
<tr>
<td>1940</td>
<td>510</td>
</tr>
</tbody>
</table>

94 A report in 1922 to the Hospital Association from Dr. Charles H. Mayo, Rochester, Minnesota, cited a study of St. Mary’s Hospital in Rochester showing that 31% of the nurses graduated from that school over the previous 10 years had married. "Hospital Association, 1922: Round Table", *Canadian Nurse*, 1922.

95 Weir, *Survey of Nursing Education in Canada*, p. 68.

96 DBS, *Census* 1931, 1941.

97 MARN "Binoculars Lifted" May 7, 1948. p 1 (MARN Library).

98 Ibid.

99 Ibid, pp. 1, 4.
Chapter 4
Tripping down an alluring path into a garden
of great adventure in private duty nursing:
Winnipeg as a Case Study

As investigators such as Weir documented, the economic crisis of nursing in the interwar decades effected nurses in every region of Canada. Yet the crisis itself is best understood within the context of specific, local health systems, in which nurses trained and worked. This chapter explores the component parts of one such local system, that of Winnipeg, Manitoba, and the relationship among institutions, the nursing workforce, and the health care market. As this case study reveals, hospitals played a critical role both in the size and composition of the nursing workforce, and also in the establishment of special duty work as a type of private care. However, hospitals' reliance on student nursing staff prompted administrators to improve working conditions, thereby maintaining nursing's popularity as a female career option. The needs of hospitals coalesced with those of young women to reinforce the sex-specific nature of nursing work. These circumstances highlight the importance of the nursing workforce as an often unacknowledged influence within the political economy of interwar health services. This investigation of nurses' role within one health care system also permits insights into the dilemma working nurses confronted as they struggled to claim value for their skills. As nurses graduated from Winnipeg's nursing schools, most "tripped down an alluring
path into a garden of great adventure in private duty nursing" that was fraught with problems.

Winnipeg's health care system was archetypal of those of other Canadian, and indeed North American, cities.. Within that system the hospital was key in influencing the size and composition of the nursing workforce, but the formal standards established by hospitals were tempered by the reality of recruiting women from the available pool of labour within the province. In particular, the WGH drew upon women from rural Manitoba and Saskatchewan and also from Winnipeg women from a variety of class backgrounds. Upon graduation, hospitals had difficulty attracting nurses to their staffs, as the prospects in private duty were greater. This changed as the interwar decades progressed. Unemployment figures from the employment bureau displayed the degree to which private nurses were affected. Efforts to improve the availability of hospital jobs stemmed from the difficulties nurses had in influencing the private market, and in limiting the amount of unpaid or domestic work nurses performed. Nurses' inability to claim standard wages undermined the image of nurse as skilled worker, while their performance of housekeeping duties blurred the distinction between nursing and maternal care.

Capital city of Manitoba, and regional centre for the West, Winnipeg provides a revealing case study of a Canadian health care system, and the crisis it created and solved for its nursing
workforce. The city's dramatic urban growth of the late nineteenth and early twentieth centuries included the creation of a medical establishment equal to that of any North American centre, be it Toronto, Montreal, Boston, New York or Chicago. By 1919, the city that W.L. Morton termed "the precocious prairie child" boasted a university medical school affiliated to prestigious teaching hospitals, religious and lay organizations and institutions, active professional and licensing bodies, numerous schools of nursing, an effective public health department, and a class-conscious medical social service agency, as well as an impressive record of medical and nursing service in the Great War. As supplier of trained personnel to both the vast prairie hinterland and to the international medical community, Winnipeg's health care system in the first decades of this century epitomized the Anglo-American model of health services development.

The creation of Winnipeg's health care system was part of the dramatic industrial and population growth of the pre-war decades that transformed Manitoba's capital into the "Chicago of the North." As the industrial and commercial centre for the Canadian west, Winnipeg was home to a large, ethnically-diverse and predominantly immigrant working-class as well as an established Anglo-Saxon social and political elite. Like other North American cities, Winnipeg's citizens shared unevenly the material resources of the urban centre. Densely-populated and poorly-serviced working-class neighbourhoods, particularly those of the "immigrant" North End,
drew the attention of urban reformers like Salem Bland, Nellie McClung and J.S. Woodsworth as well as that of citizens less concerned about social change than about the city-wide health hazards poverty produced.\(^7\) And like other North American cities, Winnipeg's political elite responded to these concerns by establishing hospitals, public health programs and educational institutions to provide medical services and protect the health of rich and poor alike.\(^8\)

By 1920 Winnipeg's modern health system matched that of its eastern counterparts, but the particularities of the prairie economy provoked early signals in Winnipeg of the crisis soon to afflict medical services in other urban centres. Minimal economic benefit from military expenditures of the First World War, and subsequent post-war events such as the elimination of preferential freight rates and the opening of the Panama Canal, changed the trajectory of Winnipeg's economic and population growth during the interwar years.\(^9\) Most significantly, the dependence of the prairie economy on wheat cash crops created an economy particularly vulnerable to the international market failures of the late 1920s.\(^10\) Economic stagnation of the 1920s, followed by the devastating depression of the 1930s, undermined Winnipeg's regional dominance of Western Canada, while crippling the financial well-being of its citizens, and the structures designed to protect their health.\(^11\)
For the workforce of graduate nurses produced by those structures, these conditions specific to the prairie metropolis accentuated the crisis plaguing nurses elsewhere in the Dominion. The contradictory forces set in motion during the first decades of the twentieth century combined to destabilize the supply of and demand for skilled nursing attendance in the interwar years. The therapeutic reliability of hospitals was built upon the success of skilled nursing staff: reliability engendered popularity, as patients and their doctors utilized institutional services with greater frequency. Hospital growth demanded increases in the size of the nursing apprenticeship workforce. Each increase in that workforce translated into greater numbers of graduate nurses available for private care. But the demand for private care was minimized by the growing demand for subsidized hospital service in a city beleaguered by economic stagnation. In the same way that pre-WWI Winnipeg served as an archetype of North American health services, so too did the city in post-war decades provide an exaggerated version of the contradictions nurses faced, torn as they were between unrestrained supply and crippled demands.

The effects of economic stagnation upon the health of the population are difficult to discern. By 1921, the efforts of public health officials had been rewarded and Winnipeg's infant mortality rate had been lowered to below 100 deaths per 1000 live births, keeping the city a relatively safer place to be born than elsewhere in
the province. In comparison with Toronto and Vancouver, cities with municipal services similar to Winnipeg’s, the prairie metropolis achieved an infant mortality rate lower than that of its Central Canadian counterpart but not as impressive as that reported for the west coast. Health reformers in all municipalities had less immediate success reducing maternal mortality and comparative statistics revealed that Winnipeggers were not alone in their inability to control the rate at which parturient women died. Rates for Winnipeg, Vancouver and Toronto varied annually and did not stabilize until the introduction of sulfa drugs in the late 1930s. In most years, numbers for Manitoba’s capital city exceeded the provincial total, although Winnipeg’s rates may have been inflated by greater availability of illegal, and often fatal, abortions in the city.

The prevalence of communicable diseases was another measure of community health. Municipal facilities provided isolation and treatment for reportable diseases ranging from diphtheria to typhoid to scabies to poliomyelitis, as well as the ubiquitous tuberculosis.
With the exception of 1936 in which an epidemic of scarlet fever brought over 1400 victims and suspected "contacts" into the "King George", a steady decline in both the number of treatments and the total patient days accompanied the less dramatic reduction of gross and corrected death rates from acute communicable diseases over
the 1920s and 1930s. Certainly in terms of the measures employed by public health statisticians -- measures such as rates of infant mortality, maternal mortality and reportable communicable diseases -- Winnipeg boasted an improved standard of health between the two wars.

Statistics documenting the decline of death and disease convinced contemporary public health officials that the health of the city's population was improving. For many the causal agent of this decline was scientific medicine as dispensed by doctors, hospitals and organizations. Yet later researchers examining the relative importance of medical intervention, standard of living, and virulence of diseases are now questioning the assumed correlation between medical science and better health.¹⁸ Thus, the degree to which medical officials were correct in taking credit for Winnipeg's improved morbidity and mortality rates awaits further study. Nevertheless, whatever the effect of doctors hospitals and public health agencies, they could not have achieved what they did without the crucial aid of the city's nursing workforce.

Nursing services were central to the impressive range of health care resources that served the citizens of Winnipeg and surrounding districts. Yet the self-proclaimed leader of the city's health care system was the medical profession, which wielded its power through the collective agencies of the Manitoba Medical Association (MMA) and the provincial College of Physicians and
Surgeons. Between 1920 and 1940, approximately 350 doctors, predominantly male, offered their private services to Winnipeg's citizens. Throughout these years, Winnipeg's medical community supported up to 384 of Canada's 4582 licensed practitioners, just slightly under the combined total for Calgary, Edmonton, Regina and Saskatoon. Many practitioners were graduates of the University of Manitoba Medical College, located on McDermott Avenue next to the Winnipeg General Hospital (WGH). Like the University itself, the Medical School was the first such body established in western Canada. Originally a private institution, the School affiliated with the University of Manitoba in 1882, and constituted the sole medical training facility in the prairie region until the University of Alberta Medical School opened in Edmonton in 1913.

Even with these educational facilities, western Canada continued to suffer shortages of physicians and surgeons throughout the first half of the twentieth century. And yet, the MMA, and parallel organizations in other provinces, followed the lead of their eastern counterparts, remaining opposed to licensing anyone but "regular" practitioners. For example, in response to the Victorian Order of Nurses' proposal to introduce British nurse-midwives to the poorly serviced Canadian north-west, Manitoba doctors echoed the sentiments of their peers elsewhere in stipulating that non-licensed competition would be persecuted, if not prosecuted. A confident MMA assured its members that, in 1934, 99.4% of all births in Winnipeg were attended by physicians, and that deliveries by
midwives had decreased from 19.8% in 1918 to a mere .06% in 1934.23 Midwives, homeopaths, chiropractors and other unlicensed practitioners continued to operate, but they did so in decreasing numbers and in marginalized neighbourhoods and communities.24 While no scholarly work has yet documented the associational or individual behaviour of Manitoba doctors in these decades "Before the Age of Miracles",25 research by leading historians of Canadian medicine, such as S.E.D. Shortt, suggests that economic and ideological forces pulled "ordinary" and "elite" physicians everywhere towards the centrifuge of exclusive professionalism.26

Securely positioned at the pinnacle of the health care hierarchy, doctors in private and hospital practice relied almost exclusively on the skilled assistance of trained nurses. If patients had not themselves secured the services of a trained nurse, Winnipeg's doctors might advise their clients to engage private nursing care.27 Moreover, when medical office-space transferred from practitioners' homes to downtown office buildings and then to "clinics", doctors started employing nurses directly. In 1921 seven graduate nurses worked at the Galloway and Gibson Clinic, situated in office buildings within walking distance of the affluent neighbourhood between Broadway and the Assiniboine River.28 In hospital, home clinic or office, nurses prepared patients for medical treatment, assisted physicians and surgeons during procedures, and remained with patients following medical interventions to complete the treatment and ensure the patients' return to health.
In the years following World War I, diagnosis and treatment increasingly occurred within the matrix of medical facilities designated for various acute and chronic, physical and mental afflictions. Six categories were utilized by administrators and legislators to characterize the structure and function of Winnipeg's health institutions. The terms "public" and "private" were invoked to describe three related but slightly different patients' financial status. "Private" patients paid the full daily cost of hospital services, either in single "private" rooms or in shared "semi-private" wards, and also paid their own physician who admitted and attended them. "Public" patients on the other hand paid very little, if any, of their costs but admission to these subsidized beds meant sharing the large open wards with twenty-five or more other public patients and receiving medical care from whichever attending doctor or intern was on duty. Most Winnipeg institutions offered both types of accommodation to the patient clientele, and therefore most hospitals received some public funding. In addition, the terms public and private were used in a second way, to differentiate between institutions governed by elected boards and those directed by private organizations, in most cases a religious group of one denomination or another. This administrative distinction did not have anything to do with the presence of public or private beds, since both private and publicly-administered hospitals advertised subsidized accommodation.29 The public-private dichotomy alluded to a third method of categorizing hospitals between those which operated for
profit, and those which did not. Some individuals earned their living by running private homes and hospitals, but these facilities constituted a small percentage of Winnipeg's total beds and were usually aimed at long-term rest cures.\textsuperscript{30} This distinction between profit and non-profit orientation was most often made by American administrators, such as those representing the American College of Surgeons "Hospital Standardization" program, for whom the issues of profit-orientation, like that of the admission of black patients, were more relevant.\textsuperscript{31}

A fourth method of institutional classification was according to the type of patients treated. "General" hospitals admitted all but contagious patients, whereas "specialty" facilities aimed their care at one particular group or debility. Furthermore, whether in general or specialty service, clientele were differentiated by in-patient or out-patient status. The former were admitted for overnight care, whereas the latter received free or subsidized treatment and returned home. Some out-patient departments had social service workers attached to them, thereby extending the hospital's work into the homes of their indigent clients. In all cases, out-patient staff investigated the financial status of their clientele so that only those patients deserving of charitable attendance received it.\textsuperscript{32} And finally, institutions were differentiated according to their educational functions. Most hospitals participated in medical training by engaging interns as in-house medical staff. On the other hand, not all institutions offered nursing education programs, some
preferring instead to hire graduate nurses for direct patient care. Between 1921 and 1941, as many as twenty-three approved schools of nursing operated in Manitoba, ranging from St. Antoine’s Hospital in the northern town of Le Pas, to the Brandon General in "Westman’s" commercial centre. While Quebec and Ontario combined hosted nearly half of all training schools in Canada, Manitoba supported more schools than any other province in Maritime or western Canada. Figure 4.2 demonstrates this national distribution of training programs.

Figure 4.2
Distribution of Schools of Nursing, By Provinces, 1931 and 1935

<table>
<thead>
<tr>
<th>Province</th>
<th>1931</th>
<th>1935</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANADA</td>
<td>256</td>
<td>202</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Quebec</td>
<td>46</td>
<td>39</td>
</tr>
<tr>
<td>Ontario</td>
<td>98</td>
<td>76</td>
</tr>
<tr>
<td>Manitoba</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Alberta</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>British Columbia</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>


In Manitoba, more than twenty schools of nursing supplied apprentice labour to their host institutions. Seven of those schools operated in conjunction with Winnipeg hospitals. Of the six city hospitals which in 1931 did not sponsor training programs, only the Dominion
Government's veteran hospital could house more than fifty patients. The vast majority of institutionalized patients in Winnipeg were attended by student nurses.

These dichotomies of public/private, general/specialty, in-patient/out-patient, and training school/graduate staff were created by the administrators and politicians negotiating the political-economy of hospital services, but they also defined patients' experiences with institutional care. In Winnipeg, five general hospitals accepted all patients, medical, surgical and obstetrical, with the exception of those diagnosed with contagious diseases. The largest such facility, the Winnipeg General Hospital (WGH) was located south-west of the CPR railyards on Bannatyne Street. A Board of Governors provided policy directives to the House administration and staff. In 1898 a second general hospital joined the WGH in providing institutional services to the "booming" city. The Sisters of Misericordia directed daily activities of their large facility situated on Sherbrook Street in the heart of the affluent Wolseley area. In contrast, Winnipeg's other Catholic institution, St. Joseph's Hospital, serviced the working-class and immigrant North End. In 1923 a Toronto order, the Sisters of St. Joseph, purchased the North End Hospital, established in 1918 by Polish-born Dr. Gerzabek, and transformed the buildings on Manitoba and Salter Streets "from a private hospital into a workable general hospital". The Victoria Hospital had a slightly different history. Founded in 1911 by local MD Thomas Beath, its facility at the corner of River
and Rose Streets stood in close proximity to the riverside homes of Winnipeg's social elite. Upon Dr. Beath's retirement, the Victoria Hospital Limited assumed management of the general "lay" hospital. The Concordia Hospital, established in 1936 under the auspices of the Mennonite church, housed fifty beds in its buildings located in the middle class neighbourhood of the city's west-end.

The Salvation Army Grace Hospital, Winnipeg's only facility specializing in maternity care, also occupied premises in the west end. The buildings at Arlington Street and Preston Avenue were constructed in 1904, and by 1933 offered 144 beds and 70 bassinets. Meanwhile, a group of community-minded women were working to provide improved pediatric care. With the support of Winnipeg's Local Council of Women, Mrs. Annie Bond, R.N. -- British-born immigrant, former nursing sister with the Royal Army Medical Corps, and wife of New Zealand doctor, J.H.R. Bond -- led the successful campaign to build a Children's Hospital. Opened in 1909, the North End buildings were "devoted exclusively to infant and child care in a locality where the infant death rate was the highest". Specialty services for contagious patients were also provided in the Manitoba capital. Built on the Winnipeg Hospital Commission's spacious Morley Avenue grounds on the periphery of the new Riverview district, the two Municipal Hospitals accommodated only communicable cases. The King George accepted the otherwise unpopular infectious patients, and next to it, the King Edward housed tuberculosis victims. More substantial sanatorium facilities were
provided in the southwestern Manitoba town of Ninette, where the Manitoba Sanatorium for Consumptives treated Winnipeg's "early" cases of pulmonary tuberculosis. Located away from the hectic pace of urban life, provincial Mental Hospitals in Selkirk and Brandon provided the spacious grounds and serene atmosphere which "moral treatment" demanded. Medical needs of convalescing veterans were met by institutions run by the Dominion Government Department of Pensions. The Deer Lodge Hospital, constructed after World War I on Portage Avenue west, was the largest of these federal facilities, and along with the smaller Tuxedo Park Military Convalescent Hospital, slowly took over from the General Hospitals responsibility for the survivors of war. Non-military chronic patients received care and accommodation at the Jessie Street Convalescent Home in Crescentwood.
### Figure 4.3

**Public Hospitals in Winnipeg, 1933.**

<table>
<thead>
<tr>
<th>Name</th>
<th>Total Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misericordia</td>
<td>225</td>
</tr>
<tr>
<td>St. Joseph's</td>
<td>109</td>
</tr>
<tr>
<td>Salvation Army Grace</td>
<td>112</td>
</tr>
<tr>
<td>Victoria Hospital Ltd.</td>
<td>97</td>
</tr>
<tr>
<td>Winnipeg General</td>
<td>661</td>
</tr>
<tr>
<td>Concordia</td>
<td>9</td>
</tr>
<tr>
<td>Children's</td>
<td>135</td>
</tr>
<tr>
<td>Shriner's Hospital for Crippled Children</td>
<td>30</td>
</tr>
<tr>
<td>Deer Lodge</td>
<td>200</td>
</tr>
<tr>
<td>Fort Osborn Station Hospital</td>
<td>40</td>
</tr>
<tr>
<td>Convalescent</td>
<td>50</td>
</tr>
<tr>
<td>Municipal Hospital</td>
<td>330</td>
</tr>
</tbody>
</table>

Source: DBS, *A Directory of Hospitals in Canada*, 1933

In Winnipeg, only the Healthwin Hospital, Hydrotherapy Health Home, Wood Sanatorium, and Mineral Springs Sanatorium were classified as profit-oriented private facilities. The vast majority of Winnipeg's health institutions, be they general or specialty, privately or publicly administrated, were considered non-profit and therefore qualified for provincial funds to subsidize public beds.

For patients the existence of public versus private beds proved extremely important in defining their hospital care. As the reminiscences of T.C. Douglas revealed, the availability and
accessibility of facilities and practitioners sharply differentiated
the experiences of classes of patients within the city. Leader of
the Saskatchewan CCF and champion of universal health insurance,
Tommy Douglas became committed that "people would be able to get
health services...as an inalienable right of being a citizen of a
Christian country" as a result of his experiences in the Winnipeg
health system. Douglas' account of receiving treatment for recurring
osteomyelitis in his knee educated him in the perils of medical
charity.

My father was an iron moulder and we had no
money for doctors, let alone specialists. After we immigrated to Canada the pain in my
knee came back. Mother took me to the out-
door clinic of a Winnipeg hospital.

They put me in a public ward as a charity
patient and I still remember the young house
doctor saying that my leg must be cut off.

The intervention of an orthopaedic surgeon who was perusing the
wards "looking for patients he could use in teaching demonstrations"
resulted in a new diagnosis and Douglas' leg was saved. Douglas'
gratitude to the medical profession did not blind him to his near-
fate as a "cripple"

Had I been a rich man's son the services of the
finest surgeons would have been available. As an iron moulder's boy, I almost had my leg
amputated before chance intervened and a
specialist cured me without a fee...
His childhood experience as a public patient in Winnipeg's hospital system strongly influenced his political vision. In 1960, when Saskatchewan was on the brink of introducing "compulsory prepaid medical care insurance", the first in the nation and a model for other provinces, Douglas proclaimed "all my adult life I have dreamed of the day when an experience like mine would be impossible".48

For other public patients, the financial capabilities of an institution, rather than chance-encounters with specialists, determined the services hospital patients received. Institutions provided public patients with the possibility of specialty care, medications and mechanical supports which many could not afford on the private market. For instance, in 1923 the Winnipeg General wrestled with this dilemma when the question of insulin treatment was raised before the House Committee. While the Junior Red Cross supplied free insulin to poor children, impoverished adults benefitted from no such supply. The House Committee decided the WGH could not afford to supply the drug to its Diabetic Out-patients even though members understood the ramifications of such a decision: "unless treatment could be continued, possibly for years, it was useless giving it".49 and diabetic adults would have to finance their own insulin treatment, or go without. Hospitals' strained financial resources thus limited the potential benefits of institutional services.50
For patients not willing or able to utilize institutional services, but who could not afford the domestic assistance of a private physician or nurse, the Victorian Order of Nurses (VON), the Margaret Scott Nursing Mission (MSNM) and the Mount Carmel Clinic could be called on to provide inexpensive or free nursing care, and contact with one of the few doctors in the city willing to provide charity care. The Winnipeg VON branch was established in 1902, five years after the founding of the national organization. Like VON organizations in other Canadian cities, Winnipeg's Order comprised a volunteer board responsible for administration and fund-raising and a paid staff of "public health" nurses. Their clientele included citizens of every class, coming from the smallest shack in the north end to the Wellington Crescent district, but in the main part they belong to the working middle class.

These patients received "bedside" nursing, one-to-one patient care in the patient's home, and were charged minimal fees scaled to their income. The Metropolitan Life Insurance Company arranged a policy with the National VON so that for a small fee policy holders could call upon the Order. This service was particularly well used for maternity cases, which in the early years of the interwar decades comprised the majority of VON work. As hospitalized deliveries became more popular the number of confinements attended by VO nurses decreased.
While the services of Winnipeg's Victorian Order found their counterpart in that organization's work in other urban centres, Winnipegers boasted two unique agencies, the Mount Carmel Clinic and the Margaret Scott Nursing Mission, both located in the working-class and immigrant community of the city's North End. Mrs. Margaret Scott began her charitable work in the 1898-1904 years, visiting the the destitute in their homes, and offering food and clothing to impoverished families. The financial support of reform-minded Winnipegers enabled Mrs. Scott to extend her relief work with the establishment of a nursing mission in 1904. Permanently located at 99 George Street, the original nursing staff of one was expanded to four in 1905, in which year alone over 7000 home visits were made. A year later, a mutually beneficial affiliation with the Winnipeg General Hospital supplied the Mission with senior student nurses and permitted Mission work to grow substantially, to which the 1913 service record of 28,830 home visits attested. A 1926 contribution to the Canadian Nurse, "Around the City with the Margaret Scott Mission", chronicled the work of student nurse Isabella Craig as she visited patients of Italian, Russian, Roumanian, German, English and Scottish origin. Her conclusions emphasized the relationship between immigration and poverty that particularly debilitated women.

[nurses] come back to hospital with a new feeling for the public ward patient, particularly the poor foreign woman, having
seen her in her own home, realizing how hard is her life and the extent of her love for her family...58

According to Miss Elizabeth Beveridge, a 1904 graduate of the WGH and Mrs. Scott's first lieutenant until the late 1930s, the Mission's founder won ready recognition for her work:

A friend who knew of [Mrs. Scott's] strenuous life gave her a pony and buggy to help lighten her work. Needless to say Mrs. Scott took great pleasure in driving a nurse going to an outlying district or one who had a parcel to carry, and in time she and her little pony became well known throughout the city.59

Mrs. Scott continued to live at 99 George Street long after she was able to drive her pony on the automobile-crowded urban streets. Despite her withdrawal from the day-to-day functions of the Mission, the "Jane Addams of Winnipeg" remained greatly respected in the community, and with the young nurses representing her.60

Throughout the 1920s and 1930s Scott's formal leadership of the Mission ensured continued support from the local medical community, the individual doctors who attended indigent patients at her call, and the private and public funding agencies.

As the Margaret Scott Mission provided medical services created by poverty, a second agency, the Mount Carmel Clinic, filled the gap created by racism. Originally attracted to the North End of the city by the availability of cheap housing, the Jewish and Slavic communities of Winnipeg soon established business, professional,
religious, and cultural institutions there which helped these immigrants survive the ethnic discrimination which marred the city's early history. In the 1920s, the overt hostility of the pre-World War I years was superseded by more subtle forms of exclusion, such as the quota of Jewish and Slavic students enforced by the Manitoba Medical College. Limitations on the training of medical personnel, combined with the impoverished financial and physical state of many Jewish immigrants, created specific health needs within the Jewish community. These needs were met in 1926 by the opening of the Mount Carmel Clinic. Originally located in a redecorated house at 263 Pritchard Avenue, sustained fundraising within the Jewish community resulted in the 1929 construction of a new clinic facility at 120 Selkirk Avenue. The almost exclusively immigrant clientele utilizing the free services of the Mount Carmel staff during the 1920s, shifted during the 1930s to include greater numbers of second-generation Jewish and non-Jewish citizens. Of the 910 cases treated in 1936, over seventy per cent did not even pay the fifteen-cent registration fee. By the mid 1930s community fundraising was assisted by the introduction of an annual grant of $500 from the provincial government. Shifting demographic and economic forces led to the decrease in use of the clinic during the Second World War and the post war years. It was not until 1948, when WGH School of Nursing graduate Annie Glaz (now Ross) joined the Clinic staff, that the facility was resurrected as a central health service in Winnipeg's North End.
Whether employed by charitable organizations, individual doctors, institutions, or the patients themselves, the "bedside care" nurses provided was part and parcel of standard medical therapeutics. Of course, many patients did not have to wait until illness struck before their first encounter with a trained nurse. Agencies dedicated to preventing the occurrence of disease or debility followed the lead of doctors and hospitals, employing nurses to dispense their services in the crusade for public health. As was the case in most North American cities, Winnipeg's urban leaders were slow to provide meaningful city health services. For instance, it was not until public pressure forced the City Council to introduce "a comprehensive health bylaw" in 1899, that complete mortality statistics were compiled. And it took the typhoid epidemic of 1904-1905 before substantial funding was granted to the municipal Board of Health. In 1906 Winnipeg's enlarged public health budget of $130,000, almost four times that of 1904, provided salaries for a new corps of 34 health inspectors, responsible for reporting communicable diseases and violations of health by-laws. However valuable the statistics, and the fines, they collected, this reporting procedure alone could not stem the tide of problems such as high infant mortality rates. The establishment in 1911 of the School Board nursing program, responsible for "inspecting" and educating public school children, was the city's first foray into direct financing of public health nursing. Up to that point, the city had left such services in the capable hands of private institutions.
such as the Margaret Scott Mission, providing public funds to supplement private donations the Mission received.

Thus while the development of Winnipeg's public health services was a story familiar to health reformers in other North American cities, the willingness of the city government to fund private and public medical services represented a pattern uncommon south of the 49th parallel. Particularly in western Canada, where provincial and municipal governments established financing schemes for hospitals and health insurance, the allocation of public funds for health services was accepted and expected. As early as 1910, the Manitoba legislature had implemented the "Hospital Aid Act", granting municipalities financial assistance for hospitalized citizens. The revised 1923 Act guaranteed a provincial subsidy for public ward patients who paid a daily rate of only $1.50-$2.00 for a bed in one of the 25-40 bed wards. Further revisions in 1929 placed institutions run by the City of Winnipeg in the same funding bracket as all other provincial hospitals. This legislation differed from that of Saskatchewan, where provincial funding provided for the construction of hospitals in the municipalities themselves rather than subsidizing patients' accommodation in already established facilities, but the concept of financing health services from public coffers was well established in the Canadian mentality. Such legislation was reinforced in Winnipeg by the municipal agency responsible for collecting outstanding patient fees for hospital service.
Three features of Winnipeg’s health care system had particular impact on the fortunes of nurses working in it. First, the entrepreneurial model of medical practice prevailed during the interwar decades. Private practitioners cared for their private patients, either in patients’ homes, doctors’ offices or hospital wards, and professional legislation ensured that only those individuals licensed by the College of Physicians and Surgeons could practise medicine in the province. Patients receiving charitable attendance in hospital public wards, from institutional out-patient departments, or through the VON, Margaret Scott Mission or Mount Carmel Clinic were attended by whichever doctor was appointed, and patients’ indigent status was investigated so that charitable services did not compete with private practice. Secondly, while the model of private practice remained in place during the 1920s and 1930s, public funds were allocated to the medical system. Almost all institutions in Winnipeg received government assistance for their public bed service. While this service was defined as charitable, the precedent was firmly in place for public funding of hospital services, and Winnipeg hospitals did not have to rely on private donations of the social elite to sustain institutional services. And thirdly, doctors, hospitals, and public health agencies depended upon the labour of nurses to maintain health services. As the number of hospital beds increased in the city, and as patient demand for public bed service intensified, so too did the number of nurses accepted by schools of nursing grow.
The pattern evinced by Winnipeg hospitals was similar to that of hospitals elsewhere in the Dominion. The number of students accepted shifted with the needs of each institution, and any increase in the number of beds available, either through enlarged facilities or reduced lengths of patient stay, forced nursing superintendents to augment their nursing staffs, usually after the increased bed capacity had strained to the limit the existing personnel. Additions to Winnipeg facilities in 1919, 1923, 1926 and 1931 added approximately 200 beds to the city's total, taking the total number of beds at all facilities to just under 20,000 by 1934. By the early 1920s 600 beds and cribs were available for patient use at the WGH, a figure which grew only slightly during the interwar years. Within Manitoba's largest General Hospital the total number of in-patients treated during those years increased to a high of 14,000 in 1929, and then dwindled to a decade-low of 12,000 in 1934. The following chart (Figure 4.4) plotting the total patient days and the nursing staff for the 1917 to 1940 years demonstrates the difficulty WGH superintendents experienced trying to raise the number of nurses to meet the heavy patient demand in the 1920s. During the 1930s, figures for patient size and nursing staff appeared less at odds.
Source: Winnipeg General Hospital, Annual Reports, 1917-1940

Records of the WGH House Committee proved that this correlation was not accidental. In 1921 General Superintendent Stephens reported to his medical staff that the

...shortage of pupil nurses still exists to a marked degree throughout the country although not to the extent of last year. Campaigns are going on all over the continent in order to encourage pupil nurse applicants.72

The Superintendent concluded that maintaining and increasing services depended upon the continued growth of student staff.73 A decade later fiscal strain prompted hospital administrators to reduce, rather than increase, patient services, and the size of the apprenticeship workforce was again tailored to meet institutional
need. The graduating class of 1935 was particularly affected by depression finances. Beryl Seeman recalled that her class of 1935 was "particularly hit" by WGH's decision to reduce the student workforce, and many who started training with her "didn't make the grade" as probationers and were sent home.74

Regardless of annual shifts in the number of nursing apprentices or graduates, throughout the interwar period nurses, graduate and student, comprised the majority of institutional personnel. In 1931 the 1561 beds available at the Children's, Misericordia, Saint Joseph's, Victoria, Municipal and Winnipeg General Hospitals were serviced by 40 Interns attached to the various institutions, 109 Graduate nurses and 469 Student nurses.75 In 1934 the Dominion Bureau of Statistics tabulated that Winnipeg's eleven hospitals could accommodate 1925 patients, and 172 newborns. 39 Salaried doctors and 43 interns maintained regular presence in these hospitals, available should the 152 Graduate Nurses and 378 Student nurses need to call them. 301 Attending doctors admitted their patients, each requiring assistance from the charge nurse and her staff.76

Each increase in the number of students accepted at WGH, combined with similar growth in the size and number of training schools at other institutions, augmented the graduate nurse workforce three years later. Winnipeg's population of student and graduate nurses grew from less than 900 in 1921 to over 1200 two
decades later. At each Dominion Bureau of Statistics investigation, nurses represented approximately 5% of the city's female workforce. The number of student nurses remained constant at 1.8-1.9% of the female workforce. Census figures for Winnipeg listed only 879 students and graduate nurses in 1921, 735 graduates and 476 students in 1931, and 834 graduates and 460 students in 1936, and only 732 plus 503 in 1941. Research of the Henderson's Directory provided similar figures. 814 "nurses" were listed in the 1921 Directory, as compared to 1226 included in the 1931 publication.77

This workforce was augmented annually through two sources. Each year, Manitoba's hospital schools of nursing produced personnel qualified to claim "Graduate Nurse" status, and eligible to write the Manitoba Association of Registered Nurses' (MARN) provincial examination. Some trained nurses elected not to write, or failed to pass, this academic measure. Successful completion however earned graduate nurses the right to attach "R.N." after their name, to become members of the provincial association, and to register with MARN's employment directory. In addition, each year a small number of women applied to the provincial licensing body for "reciprocal" registration. MARN's registration chair recommended these names to the Board of Directors. Provided the nurses possessed registration certification from another Canadian province, an American state, or occasionally a British school, they were awarded Manitoba R.N. status. For example, at the March 11, 1929 Board meeting of MARN, six nurses were granted reciprocal MARN membership:
Miss Eva Mary Miller, Graduate of St. Joseph's Hospital, Winnipeg, Registration Certificate from Saskatchewan.
Miss Mary Elizabeth Ring, Graduate of Fall River General Hospital, Fall River, Mass., Registration Certificate from Mass.
Miss Helena Ryan, Graduate of Pembroke General Hospital, Pembroke, Ontario, Registration Certificate from Ontario.
Rev. Sister St. Tiburce Graduate of the Misericordia Hospital, Montreal, Quebec, Registration Certificate from Quebec.
Rev. Sister St. Mathew Graduate of the Oak Park Hospital, Oak Park, Chicago, Illinois, Registration Certificate from the State of Illinois.
Miss Julia C. Murphy, Graduate of the St. Vincent's Hospital, Toledo, Ohio, Registration Certificate from the State of Ohio.  

Rarely were more than half a dozen names put forward at each Board meeting. MARN approved only 223 reciprocal registrants during the 1914-1934 years, as compared to 3044 Manitoba graduates who met RN examination standards.  

Figure 4.5 lists the numbers of locally trained additions to the provincial pool of Registered Nurses.
### Figure 4.5
Graduates of Manitoba Schools of Nursing Gaining RN Status 1925-1937

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Graduates Gaining RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGH</td>
<td>864</td>
</tr>
<tr>
<td>St. Boniface</td>
<td>508</td>
</tr>
<tr>
<td>Misericordia</td>
<td>206</td>
</tr>
<tr>
<td>St. Joseph's</td>
<td>54</td>
</tr>
<tr>
<td>Victoria</td>
<td>56</td>
</tr>
<tr>
<td>Grace</td>
<td>26</td>
</tr>
<tr>
<td>Children's</td>
<td>166</td>
</tr>
<tr>
<td>Brandon General</td>
<td>217</td>
</tr>
<tr>
<td>Dauphin General</td>
<td>30</td>
</tr>
<tr>
<td>Carman General</td>
<td>40</td>
</tr>
<tr>
<td>Portage la Prairie</td>
<td>65</td>
</tr>
<tr>
<td>Selkirk General</td>
<td>27</td>
</tr>
<tr>
<td>Virden</td>
<td>17</td>
</tr>
<tr>
<td>Neepawa</td>
<td>30</td>
</tr>
<tr>
<td>Souris &amp; Glenwood</td>
<td>25</td>
</tr>
<tr>
<td>Morden Freemason</td>
<td>27</td>
</tr>
<tr>
<td>St. Anthony's</td>
<td>6</td>
</tr>
</tbody>
</table>

Total 2264

Source: MARN, Registration Cards 1925-1937

While many of these schools were located in small-town hospitals which housed few patients, the majority of Canadian training programs and the majority of students were located in the large urban centres. Federal government statistics verified this pattern. For example, between 1934 and 1939 the combined efforts of
Winnipeg and St. Boniface institutions trained over 75% of Manitoba's student population. Of the nearly 3000 new graduates MARN recommended for Registered Status between 1918 and 1939, over 2284 had attended training school in Winnipeg. According to MARN's standards, Winnipeg General Hospital supplied nearly two times as many Registered Nurses to the provincial pool as the next largest institution, St. Boniface, and 35% of the provincial total.

As the determining factor in the number of nurses produced annually Winnipeg's hospitals were critical influences upon the composition of the nursing workforce. Given the close working relations between doctors and nurses, the medical establishment maintained a keen interest in the education and practice of trained nurses. Medical support for nursing education came in the form of lecture time, donated by doctors to the perpetually underfunded nursing schools at the various hospitals. But for the most part, the medical community entrusted their "Lady Superintendents" with the responsibility of creating and maintaining an adequate supply of skilled nursing personnel. In 1921 the WGH Medical Advisory Committee outlined the qualities they sought in their Nursing administrators:

the Superintendent of Nurses...should be an outstanding woman in her profession, broad in her sympathies, tactful [sic] and humane...be able to meet the public, have a wide and varied knowledge of Hospital administration and government, be able to handle the nurses well and be in sympathy with the WGH
Alumnae... should keep more in touch with the Staff, that she should have plenty of opportunities of meeting with the Board and the Staff executives which might possibly relieve any little points of friction...\(^{83}\)

Faced with this demanding job description women such as the Victoria Hospital's, Alice Besant, WGH's Kathleen Ellis, Sisters M. St. Albert, M. St. Egbert and St. Irma of St. Joseph's, Sisters of Misericordia St. Bertha and Mary of Jesus, and Municipal Hospital administrator Elsie Robertson all claimed "RN" status as credentials to groom a new generation of trained nurses.\(^{84}\)

These second-generation graduates who assumed leadership in the city's hospitals, and often in local nursing associations,\(^{85}\) defended staunchly their need for autonomy in running their school, and served as benefactress for their nursing staffs.\(^{86}\) At the same time, their ability to do that depended on providing a workforce tightly disciplined, properly trained and therefore indispensable. Thus while the hospitals' short-term needs influenced the number of students superintendents accepted to apprentice at her particular hospital each year, the institutions' dependence on nurses to staff their wards, and the superintendents' reliance on successful nursing care to maintain the status of all nurses, served to ensure that the hospital nursing school remained sensitive to the needs of its female workforce. As Charles Rosenberg emphasized for American nursing schools:

\[
\text{Education and the credential it legitimated had become both inducement and part payment for a}
\]
key segment of the hospital's labor force. This was an economic logic too compelling to be ignored. Both hospitals and prospective nurses were capital poor; it was only natural for the two parties to barter: work for diplomas.87

In the Canadian setting, a similar barter system governed hospital-nurse relations. Nursing superintendents' decisions regarding the number of nurses trained each year, and the criteria established to maintain quality service, were influenced by the preferences of and options available to the women being considered for admission and the need to keep their schools attractive educational options and nursing an attractive occupational option. As was the case in every region, institutional staffing needs of Winnipeg's general and specialty hospitals determined the size and composition of the nursing workforce, but those same needs ensured that hospitals remained sensitive to the needs of working women.

The balance of power between hospital needs and the pool of potential apprentices was maintained by nursing superintendents through the formal educational standards they set and their sometimes informal method of implementation. Formal admission standards varied slightly at each institution, and tended to shift over the interwar decades. In general however, age, education, personality, and health standards were employed to eliminate "misfits" from the profession.88 Together these attributes aided nursing superintendents in their perennial quest for "quality applicants" possessing the maturity and stamina to survive three
years of heavy labour. Winnipeg hospitals advertised that applicants younger than 19 years of age were accepted only if "particularly well fitted for the work", while the upper age limit for admission was between 30 and 35 years of age. Prior to World War I, at least one complete year of high school was asked of students, and by the mid-1930s most institutions required students to have finished grade 11. For example, in 1914 the St. Boniface Hospital accepted pupils with grade 9, but by 1930 a complete grade 10 standing was required and in 1936 a complete grade 11.89 Not surprisingly, the more prestigious the hospital the more elevated the standard. As early as 1928 WGH, Winnipeg's "most prominent" institution, announced

An educational standing of Grade XI, or its equivalent, is accepted, though preference will be given to those having more advanced standing or better preparation, personality, and maturity of judgment for the practice of nursing.90

The difficulty such high standards caused for some institutions was reflected in the fact that two years of high school was not established as MARN's provincial standard until 1941.91

For superintendents at all institutions, the degree to which official educational and age criteria were enforced varied. Mary Shepherd's first application to the WGH was kindly rejected by Superintendent Mary Martin. In a letter dated January 6, 1925 Martin advised the young applicant:
As you are still very young for a nursing course I would advise your staying as long as possible in school, at least until after your eighteenth birthday, and you will have then finished you High School Course, I should be glad to consider your application. Your letter and application form would indicate a capable young woman, and I should be glad to have you call to see me when you come to Winnipeg...92

The following month, however, Shepherd received her letter of acceptance, and was instructed to "report for probationary term between 10 and 5 pm on September 1st".93 This kind of rule-bending occurred periodically at every hospital in the city, but for the most part superintendents selected those students with greater rather than lesser age and education.94 Of the nine graduates from WGH, Misericordia and St. Boniface whose active participation in MARN affairs earned them entries in MARN's biographical file, all were aged 22 or more when they finished their training, and the group average was 24 years.95 Census figures corroborated the ages in training of MARN's activists. The 1931 Census found only 1 student nurse in the 16-17 years of age category and 3 over 35 years of age. Of the remaining majority, the greatest concentration occurred in the 20-24 years of age category. Competition from other job options for women during World War II led to 63 candidates in the under 18 age group being accepted by Winnipeg programs in 1941, while only 7 students were accepted between the ages of 25 and 34.96
The age limits set by MARN and enforced by hospital administrators served to keep the educational qualifications of nurses relatively high in comparison with working women in other occupations. Many aspiring nurses had to "wait a year" before entering training, during which time they worked at other jobs, or at home. Mary Shepherd worked in her father's store for a year until she was old enough to begin her nursing education. Determined to become a nurse, Shepherd calculated that her year of clerking would help her "get used to standing all day" once training began. Other nurses were less sure of their career goals and pursued employment in other fields before entering nursing. Teaching in particular lost numerous new recruits to nursing. Mable Lytle and Olive Irwin both preferred nursing over teaching. Ingibjorg Cross convinced her older sister to end her teaching career and become a nurse. Myrtle Crawford, whose first career choice was nursing, followed her father's advice and taught for two years before joining her sister Ruby in nursing's ranks. Some, like Isabel Cameron, Grace Parker and Anne Ross, attended university before continuing their education in the hospital, while others such as Beryl Seeman stayed at home and helped with farm and home chores before beginning their apprenticeships. Thus nursing capitalized upon, rather than competed with, the growing number of girls from all class backgrounds who were earning their high school diploma. This pattern continued through the 1930s. The 1936 Census of the Prairie Provinces calculated that of the 45,811 women in all occupations,
most, 53%, had 9-12 years of education, while another 8% had 13 years or more. In contrast, 73% of Graduate nurses claimed they had 9-12 years, and 21% boasted 13 years or more.101

Objective standards of age and education were not the only measures of suitability for nursing programs. Testimonials verifying a candidate's superior personality and health served as further documentation upon which nursing administrators based their decisions. "Personality" was established through letters of recommendation, one from the applicant's minister or priest, and one from her physician. Over the course of the 1920s, clerical testimony as to the applicant's "good moral character" was superseded by medical certification, a transformation which spoke less to the ascendance of "doctor as priest" than to the real problem of ill-health among nursing students.102 Thus pre-war medical letters "certifying sound health and unimpaired faculties" were no longer sufficient in the 1920s. Rather, certificates of physical fitness, statements of immunization and family health histories were all required. Accordingly, when WGH Superintendent Kathleen Ellis boasted in 1931 that

...there is a long and satisfactory list of applicants from which to draw, making it possible to give preference to those with higher educational standing and of more mature years...

she also acknowledged the necessity of good health to survive hospital training.
...each student is now required to submit to a yearly health examination in addition to the thorough preliminary investigation made concerning the physical condition and family history of each candidate before she enters the school....103

While commanders-in-chief like Ellis realized the good health of her troops was essential both for the day-to-day tasks of running an institution, she also recognized that the reputations of both her school and her occupation had to be maintained if she was to recruit young women to the WGH. For example, throughout the interwar decades, Superintendents of Nursing used annual reports to publicize the popularity of nursing, and of their school, to the provincial elite. Immediately following WWI and the influenza epidemic WGH Superintendent of Nursing Charlotte Powell reported that the WGH nurses who had served overseas had returned "filled with pride in the reports of the work done by them in the hospitals of England and France, where they have upheld the best traditions of their Hospital" 104 Three years later Superintendent Mary Martin argued in her report that the 120 students who enrolled in the "1925" class, boasted the highest educational qualifications than previous classes and that surely this fact must increase our responsibility to provide for them that superior type of teaching which alone will meet the newest demands and opportunities in nursing work.105
Such information reflected as much about the occupational image administrators tried to maintain, as about the real demand for entry into nursing schools. This became pronounced during the 1930s when overwork and poor health of nursing students, as well as underemployment of graduates, inspired the authors of the Annual Reports to emphasize the increased number of women enquiring about WGH program. Yet in 1936 the Superintendent of Nursing Ellis reported that only 34 new students entered the WGH, and only 39 had arrived the previous year.106

The degree to which superintendents could reject or accept applicants depended upon the available supply of educated young women interested in pursuing a career in nursing. City limits were irrelevant to this supply and women from not only Manitoba but all provinces sent their applications to Winnipeg schools.107 Numerical evidence from the Winnipeg General Hospital substantiated the particular significance of nursing education to women from rural Manitoba and Saskatchewan, and of those women to nursing programs. Of fifteen WGH graduates interviewed, ten spent the majority of their public school years in rural Manitoba, and one hailed from rural Saskatchewan. Only two were raised in Winnipeg, while two others spent half of their childhood years in Winnipeg, but the other half in rural communities.108 Over the 1924-1929 and 1931-1939 years, 37% of WGH graduates originated from Manitoba districts and towns other than Winnipeg or Brandon, and a further
22% listed townships in rural Saskatchewan - other than Saskatoon and Regina - as their homes. Almost one third claimed urban residence, 29% had families in Winnipeg, but very few Brandonites, only 1%, had chosen WGH over the Brandon General program. The small number of women from western Ontario towns such as Keewatin, Fort Francis and Port Arthur-Fort William (the Lakehead) demonstrated the continued importance of Winnipeg as a regional centre for Canadians living west of Lake Superior. Annual variations are reported on Figure 4.6.
Figure 4.6
Hometowns of Winnipeg General Hospital Graduates, 1924-1939
Only in 1925 did city dwellers outnumber graduates from rural Manitoba. The even proportion of Saskatchewan-born graduates of the 1920s, contrasted with relatively dramatic fluctuations in the 1930s. Between 1931 and 1934 the number of women from rural Saskatchewan peaked. Substantially fewer Saskatchewan natives graduated in the mid-1930s when the WGH reduced both its patients load and its student workforce, but then the hospital attracted or recruited greater numbers again in the years immediately preceding World War II. Since nursing guaranteed room and board it was a sensible choice for rural women facing limited options, either marital or waged, in their small communities.110 Those options were further reduced in the 1930s when the agricultural crises of droughts, plagues, and low grain prices left displaced many prairie-ites.111 While their brothers rode the rails looking for work and handouts, rural women went to nursing school.

Not all these women came off the farm. Many were residents of small towns which offered little waged work, and even fewer eligible men. Mary Duncan, Mary Shepherd and Harriet Pentland grew up in the towns of Glenlyon, Buelah and Boissevain Manitoba where their fathers operated dry and "fancy" goods stores.112 To these women, inheriting the family enterprise was not an option. As long as a son existed, prairie women, whether living on a farm or in a small town, were unlikely inheritors of family property, and once a brother married the labour of his sister was made redundant by that
of his wife. Urban hospitals were the unintended benefactors of inheritance patterns which dispossessed the daughters of the countryside.¹¹³

For the women administrating nursing programs, rural applicants were a welcome supplement to the local talent pool. The city-born not only enjoyed greater occupational choice, but the close proximity of their families permitted, and maybe even encouraged, them to quit school more easily.¹¹⁴ Superintendent of Nursing at Brandon General Hospital, Miss Christina Macleod, was accused in 1935 of "discriminating" against applicants from Brandon, and was instead selecting women from the surrounding countryside. A "head count" by the Board of Directors' Mr. Robert Darrach acquitted MacLeod of the charges, but his conclusion that "equal consideration...[had been] given to both town and country" suggested the significance of the rural districts to the hospital labour market.¹¹⁵

Rural women were conscious that their employment options were limited. Violet McMillan's recollection that

There was only two things you ever did...most of the girls just married and lived and stayed there as farmer's wives...I didn't want to do that, I don't know what prompted me to because I'd never seen a hospital in my life, I'd never seen a nurse in my life, but there was only two things that girls did in those days they were either school teachers or nurses...I sure wouldn't make a good school teacher so I decided to become a nurse...I think there was one other girl from the
Swan River Valley that I know of that became a nurse...they all went to Dauphin to be school teachers...[Didn't know anyone else when she began her training at WGH] As I look back now I don't know how I had so much nerve because we were pretty green coming out of the country and no radio no TV's no communication with the outside world really...my people lived on the farm we had the telephone and that was all...we didn't have a paper or anything like that...something must have told me to [become a nurse] because as my life unfolded I needed that, I had to have that to make a living twenty five years later.116

The work experience of WGH graduates interviewed verified that white collar options of teaching and sales clerking were the only two other options pursued by nurses. Two were conscious that nursing was second choice. One retired WGH nurse considered other educational options, but pursued nursing when it became clear that her family did not have enough money to finance higher education for both her and her brother.117

Census reports confirmed the existence for urban dwellers of a wider range of occupational choices.118 Figure 4.7 compares the distribution of women workers according to key occupations for Winnipeg and Manitoba.
Figure 4.7

Women Working in Selected Occupations as Per Cent of All Women Workers, Winnipeg and Manitoba, 1936

<table>
<thead>
<tr>
<th>Occupation</th>
<th>% of Total Working in Each Occupation</th>
<th>Winnipeg</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Working Women</td>
<td>100% (24,267)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Nurses, graduate</td>
<td>3.4%</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>Nurses, student</td>
<td>1.9</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Teachers</td>
<td>5.6</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Bookkeepers and Cashiers</td>
<td>3.0</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Stenographers and Typists</td>
<td>15.0</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>Other Clerical</td>
<td>7.0</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Lodging and Boarding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House Keepers</td>
<td>4.4</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Domestic servants</td>
<td>19.2</td>
<td>26.3</td>
<td></td>
</tr>
<tr>
<td>Waitresses</td>
<td>3.3</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Packers, Wrappers and Labellers</td>
<td>1.7</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Saleswomen</td>
<td>9.5</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Telephone Operators</td>
<td>1.0</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Sewing Machine Operators, Factory</td>
<td>3.4</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Textile Goods, Wearing Apparel</td>
<td>6.7</td>
<td>4.5</td>
<td></td>
</tr>
</tbody>
</table>

Source: DBS, Census of the Prairie Provinces, 1936

While graduate and student nurses constituted the approximately same proportion of Winnipeg's female workforce as that of the provincial total, in almost every other female-dominated occupation, provincial figures are lower than that of the capital city. Teaching
and domestic service are the two exceptions. Together those two occupations accounted for 35% of Manitoba's gainfully employed women, and 47% of the total when Winnipeg figures are excluded. Urban residents such as Jean Ewen took advantage of Winnipeg's employment options when in 1927 she secured work in the laundry of St. Joseph's Hospital. Within two years Jean had taken on a new role in the hospital, as a student nurse.119

Many other Winnipeg women, like Ewen, chose nursing, and left their family homes to apprentice in the city's hospitals. Evidence depicting the family background of Winnipeg-raised nurses substantiated Weir's documentation regarding class background of Canadian nurses. Nurses hailed from a variety of class backgrounds and from every district of the city.120 Working-class women were well represented in the occupation, and at least some received early educations in working-class consciousness and politics. Jean Ewen claimed that she and her siblings became "of necessity, independent, self-reliant brats" while her father became increasingly involved in Communist Party politics.121 In 1931 Winnipeg graduate nurse Brenda Farmer resided with her family in their Riverview home. Her father, Seymour James Farmer, was a trained chartered accountant who turned his attention to labour politics in the post-World War I years. Farmer was successful in two mayoralty contests and in 1931 was serving his third term as a Member of the Legislative Assembly.122 It is unclear whether Brenda and her three brothers shared their father's working-class political beliefs, but they did
share his "white-collar" occupational category. John and Lloyd were
employed as clerks in the private sector, while John worked as a
teller for the Province of Manitoba. Across town, graduate nurse
Agnes Puttee lived in her family's College Street residence with
sister Winnifred, a teacher, and brothers, Arthur, an engineer with
Canadian Engineering and Construction, and Harold, an inspector for
the Bureau of Labour. Their father Arthur worked as manager of
Printer's Roller Company, and was well-known in the city as the
former Labour M.P.

The most interesting feature of available data on Winnipeg
nurses was the occupation of their sisters. Very few graduate
nurses lived in households with sisters working in the industrial or
blue collar occupations. Rather, Winnipeg nurses who returned home
after graduation to live with their families resided with sisters
working in clerical, sales, or teaching jobs. Examples from
Winnipeg's Henderson's Directory illuminates this point. WGH
graduate, Violet Crone, grew up in the working-class district of
Elmwood. Her father Frank was an employee of Priestley's grocery
store, sisters Ada and Lily were clerk's at Eaton's department store,
while a third sister Nellie was on staff at Stovel's Printing
Company. Brother Albert was employed by Brown and Rutherford's
Lumber Company. Hailing from a very different family background,
nurse Elizabeth Parker and her sister Frances, an assistant at the
Winnipeg Public Library, lived in the north River Heights home owned
by their father, University of Manitoba Professor M.A. Parker.
Such individuals exemplify the larger pattern. Regardless of the occupation listed for the men in their family, women who became nurses grew up in families where girls pursued the occupations of teacher, stenographer, librarian, salesclerk, and perhaps telephone operator. Very few nurses shared residences with sisters working in industrial production. One explanation of this phenomenon may be that women with industrially-employed sisters did not live together. A more likely explanation lies in the process whereby certain families agree to permit or endorse certain kinds of training and employment for their daughters. Further research may reveal the process whereby certain occupations become deemed acceptable by families. The pattern remains for all classes. Regardless of occupational background of nurses, be it unskilled, skilled, professional, business, certain families decided that they had the resources and valued skill for women.

Yet, oral testimonies establish that parents did not always approve of their daughters' decisions to pursue nursing training. Ingibjorg Cross' father's experience as a patient in the Virden Hospital had led him to conclude that nursing was not a fit occupation for young women. Thus when Ingibjorg informed him of her plan to enter the WGH, he refused to finance her tuition. She paid for it herself from an unusual source, from her winnings at rural sports days.124 Whether endorsed by their parents or not, women's reasons for seeking training were clear: Some kind of skilled
training was necessary, whether women married or not. Jo Mann learned that lesson from her mother's experience.

"My mother felt every woman should have something to do. She felt if anything happened to them, like she had been left with dad having lost his leg and running a farm and they told her he would never be able to work again and [that] he would be more or less an invalid. She suddenly realized she didn't have anything to fall back on. How could she earn a living for so many of us, for four children? She felt we should go to school and have a profession of some kind."

The numerous examples of women of the older generation whose nursing salaries supported themselves and their dependents was substantiated throughout nurses' careers by the experiences of their peers. Jo Mann's roommate had entered training when her newlywed husband died suddenly. Vera Chapman returned to private duty nursing when her husband of five weeks passed away. Chapman's friend and class-mate Violet McMillan also reentered paid nursing work when left as a widow to support her three children. Nursing permitted Jo Mann and many others to assume economic responsibility for their families when their husbands' death, disability or financial difficulties demanded. And of course, many women never married, and many others worked for many years before choosing a marriage partner. Figure 4.8 presents available documentation on marriage patterns for WGH graduates of the 1920s.
Figure 4.8
WGH Graduates, 1920-1928.
Never Married, and Married Within 1, 3, 5, 10 Years, and
More than 10 Years of Graduation.

<table>
<thead>
<tr>
<th>Year of Graduation</th>
<th>Never Married</th>
<th>Within 1 Year</th>
<th>Within 3 Years'</th>
<th>Within 5 Years</th>
<th>Within 10 Years</th>
<th>After 10 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>15</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>1922</td>
<td>13</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>12</td>
<td>9</td>
<td>44</td>
</tr>
<tr>
<td>1924</td>
<td>19</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>20</td>
<td>54</td>
</tr>
<tr>
<td>1926</td>
<td>19</td>
<td>4</td>
<td>12</td>
<td>4</td>
<td>10</td>
<td>17</td>
<td>66</td>
</tr>
<tr>
<td>1928</td>
<td>26</td>
<td>16</td>
<td>18</td>
<td>2</td>
<td>9</td>
<td>26</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td>27</td>
<td>45</td>
<td>17</td>
<td>43</td>
<td>75</td>
<td>299</td>
</tr>
</tbody>
</table>


Of the above sample, nearly one-third never married, while another quarter did not marry until at least ten years after graduation. For those who did marry, the experiences of older women and of their peers reinforced the importance of possessing skilled training should circumstances necessitate a return to the workforce. Skill took on new meaning for this generation. In a world of work which consistently denied women equality, which defined work according to its sex typing and valued it thus, skilled training held out the possibility of economic self-sufficiency, if not complete autonomy.

Upon completion of their apprenticeship, "the great majority of nurses tripped down an alluring path into a garden of great adventure
in private duty nursing." Thus while Winnipeg's hospitals remained the determining force in the size and composition of the nursing workforce throughout the interwar decades, they did not emerge as a viable employment option until the later years of the period. Available positions for graduate or registered nurses were few in the early 1920s. The majority of graduate nurses preferred work in the private duty sector, a phenomenon recognized by administrators throughout the 1920s. Graduate nurses resisted the transition to hospital-based employment. After three years of training most graduate nurses were sick of the hospital, and very often the hospital made them sick. Thus while nursing leaders attempted to increase the amount of work available in the hospital, the pay, hours and pace of work there discouraged graduates from accepting staff positions, or staying in them long. Nursing administrators recognized that hospital positions attracted, or from their perspective required, a special type of nurse. Miss McGillvary for example made her career as night superintendent at the Winnipeg General Hospital, perhaps because of her experience as an army nurse in World War I, or perhaps because of the financial commitments involved in raising her orphaned nieces. As early as 1920 WGH Superintendent of Nurses Charlotte Powell, RN, reported that very few of the 37 requests from other institutions for staff nurses had been filled by WGH grads "owing to the fact that so many of our graduates are interested in private duty nursing." Until the late 1930s, the MARN Directory filled relatively few hospital postings,
and in 1941 acknowledged that "at times it has not been possible to fill all calls from hospitals outside the city for general duty or staff nurses."133

Long hours, and nurses' inability to control hours of work, were critical factors discouraging graduates from accepting staff positions. The debate over the eight and ten hour day was the most striking example of this. During the final year of World War I WGH Superintendent Mabel F. Gray acknowledged that, despite the "most hearty support of the Board of Trustees", her goal to shorten the hours of duty for nurses was unrealistic:

"Owing to the lack of accommodation in the Nurses Home it has been impossible to keep the numbers up to such strength as will ensure than nurses shall never be permitted to remain on duty overtime."134

The following year, in the wake of the influenza epidemic, the Board of Trustees announced "that definite measures are being taken to reduce the number of hours on duty, and which will be put into effect in the very near future". A system of shortening the hours of night duty by giving nurses a two hour rest break during the night was attempted in October, but during the last few months of 1918 the epidemic "assumed such a serious phase...this rest period had to be abandoned."135 The shortage of nurses persisted long after the epidemic, so that efforts at "putting into force the eight-hour day" were postponed until 1920. In 1925, Superintendent of Nursing Mary
Martin translated the "eight hour day" into real terms for her audience:

The ratio of nurses to patients on ward service is based on the activity or need of the wards at any given time. For instance, the peak load on any ward is usually from 7 am to 12 noon, during which time two full meals and one light diet are served and temperatures, baths, bed making, dressings, treatments, patients doing to and from the operating rooms, and the general routine of doctors' rounds, telephone calls, charts, medical and ward house-keeping, is at its highest level. During these hours there are seven to eight nurses on duty for wards of forty beds and a higher ratio for smaller and single wards and on the maternity wards. Between 12:30 and 3 pm ward work is less active and students are then off for rest and class periods, after which patients are discharged, new patients admitted, diets served, visitors crowd the wards, temperatures, treatments, evening toilets, suppers etc covered by an increase to half of the morning staff.136

Not only were students required to attend class or study during their hours "off", but neither graduates nor students were permitted to go off duty until all the tasks for their shift were complete.137

As the 1920s and 1930s progressed, graduate nurses turned to a private duty market that was changing in two ways -- an increasing proportion of the paying clientele was utilizing institutional facilities designed for private care, and the ratio of paying patients to graduate nurses was diminishing. Private duty
nurses remained true to the private health care market, and followed patients out of the private home and into the private room. "Specialing" was not new to the 1920s. As the following excerpts from the "Guide for Special Nurses on Duty in the Winnipeg General Hospital, December 1912" indicates, private duty nurses were well-established in pre-World War I Winnipeg's hospitals.

Each Special Nurse must register in the Lady Superintendent's office before going on duty and on leaving her case ...
Nurses on Special duty are required to conform to the rules of the Training School while on duty, and are not allowed to visit or in any way interfere with patients other than the one they are on duty with ...
Nurses must wear rubber heels and must not appear in the wards except in the full uniform of their school ...
Nurses are required to go on duty and return by the basement and must enter and leave the building by the Nurses' Home ...
Nurses must report the the nurse in charge of the flat when coming on or doing off duty ...
When two nurses have been on duty with a patient and when only one is required the patient keeps which ever one he or she wishes...138

The practice of "renting out" student nurses to private patients, either for home or private room care, was more common in smaller, private hospital schools. The North Winnipeg Hospital for instance advertised in the 1920 that "The nurses on the staff visit homes; rates maternity cases $10; ordinary visits 50 cents”. 139 This practice was phased out during the 1920s however and Winnipeg hospitals only participated in the employment of special duty nurses insofar as it was necessary to contact graduate nurses for patients.
While the MARN employment service officially placed Registered Nurses in jobs as calls came in, an informal system of hospitals recommending their own graduates also operated. A 1939 MARN report stated:

The hospitals have graduated too many of whom they are not anxious to call back on cases, and is the Registry justified in sending on a case a nurse whom her own hospital refuses to call, as we are responsible to the patient and to the Doctor for the service we can give them in this respect - but of course we have to use what the hospitals graduate.\textsuperscript{140}

Whether contacted by Registrar or Alma Mater, Special nurses billed patients for their time, while the institution included the food and board for Specials in its charge to the patient.\textsuperscript{141}

As the above excerpt from the "Rules for Special Duty Nurses" suggested, specialing brought graduate nurses back within the hierarchical social relations of their student days. Yet three key features of special duty work significantly differentiated it from hospital apprenticeship or staff positions. First, a special duty nurse served only one patient during her shift. That care was delivering in a private or semi-private room which was designed and decorated to mirror a domestic setting.\textsuperscript{142} Such rooms not only separated paying patients from public ones, but special nurses from hospital students and supervisors. Secondly, special duty work ended when the patient was discharged, the nurse was dismissed or
she quit. And thirdly, special duty nurses did not have to live in hospital residence. In 1930, agents of the Henderson's Directory counted 1226 nurses living in the city. Of those, 695 lived in the residence facilities of hospitals. Only 124 employees did not live in residence. Of the 511 who did not live in residence, 115 were employed by private doctors, or by the City, Provincial, School Board and VON public health services, and the remaining number were part of the private duty workforce. Of those who did not claim hospital residence, 211 lived with their family, 20 lived at the Graduate Nurses' residence, at Wolsely Ave., and 195 lived in Boarding houses. Only 60 lived on their own, 18 lived in a boarding house with another nurse, and 16 lived with another nurse.

The available MARN Nurses' Central Directory statistics suggest that while the absolute number of calls filled by the registry rose dramatically during the 1920s, these jobs were shared by growing numbers of nurses. By the 1930s the decline in MARN calls exacerbated the imbalance between trained attendants and paying patients. Thus for many trained nurses unemployment was a fact of life long before falling wheat prices and crashing stock markets took their toll. In the words of the MARN Registrar:

As you remember, prior to 1929, hospitals all over the Continent were graduating such increasingly larger classes of nurses that a serious over-production was bound to result. The situation was suddenly made acute by the on-set of the depression in the fall of that year...
The provincial organization provided several measures documenting the severity of unemployment.\textsuperscript{146} Between 1922 and 1929 the Registrar of MARN's Nurses' Central Directory fielded 3833 requests for Graduate nurses. By 1929 this trend peaked at 5848 calls, an increase of 65%. Between 1924 and 1929, however, the Winnipeg General alone had added a possible 393 RN's to this pool, representing a 78% increase from just one institution.\textsuperscript{147} Not all nurses stayed in this pool for long. The number of nurses on MARN's Winnipeg call list remained relatively stable, numbering 267 in both 1922 and 1932, in spite of the annual additions graduating from city training programs. The January 6, 1933 report of MARN's Registrar, Annie Starr R.N., explained:

\begin{quote}
The year 1932 has indeed been a very slack year for the private duty nurses. It would appear that some of the reasons for the lack of work is that the health of the community is good, but the greatest factor is the severe financial strain that the whole community is suffering from and is now undergoing [sic].\textsuperscript{148}
\end{quote}

WGH graduate Helen Smith recalled being unemployed up to four weeks between private duty jobs. During those weeks Smith stayed "close to the phone" waiting for the registry to call. Violet McMillan received so little work during the early 1930s that she was forced to go on relief.\textsuperscript{149} By 1936, conditions had not improved. That year, of the eight occupations recording the greatest numbers of unemployed women, the highest percentage, over 22%, was among graduate nurses.\textsuperscript{150} A further numerical indicator of the high ratio
of available nurses to available work was reported in 1942. From 1938 to 1941 MARN’s Registrar did her job confident that enough nurses were available to meet any emergency. In 1938, 1939 and 1940, averages of only 16, 17, and 21 nurses were called to work of 145, 141 and 106 available, respectively. In 1941 however an annual average of only 84 nurses were available for the daily average of 26 calls, prompting the Registrar to write:

Although we have had a daily average of 84 nurses on call and this number has been adequate to meet our normal needs, if any emergency or epidemic arose we would not be in a position to cover all the demands. We are now operating upon a very narrow margin of supply.

After two decades of an oversupply of nurses, MARN officials considered anything under a 2 to 1 ratio -- the lowest ratio listed for 1941 was August’s 34 nurses on call to 20 called -- dangerously low.\textsuperscript{151}

At this local level, the demise of private duty work, either in home or in hospital, had a devastating effect. At one level it threatened to turn nurses against each other. Graduate nurses’ preference for private duty work caused tension among nurses, as the following words of the MARN Registrar revealed:

While we have a surplus of nurses, we have not a surplus of good nurses, and we certainly have too many of a mediocre calibre. The private duty field is over crowded, not because of the real private duty nurse, the
competent nurse who likes that work and intends to keep at it and has worked up a good practice, but because it is the place to which all flock who are unable to find what they want to do elsewhere...152

Such condemnation of the individual nurse as the source of nursing's woes, prevented leaders from formulating any systematic critique of the conditions under which nurses worked.

At another level severe unemployment promoted outmigration, particularly to the United States. In 1936 the Registrar speculated that unemployment amongst nurses was being kept in check by the "exodus" of 40-50 nurses to Minnesota.153 This analysis was confirmed in 1939 when the Registrar explained:

[a shortage in the US] was precipitated in the fall of 1936, when, under the Works Program Administration, a vast sum of money was voted for Public Health work. This field of employment attracted so many nurses that many of their hospitals were almost depleted of their general duty staff. They consequently turned to Canada for help. During the following ten months, over three hundred passports were issued by the American Immigration authorities in Winnipeg alone to nurses...One hundred of those being to nurses registered at the Nurses' Central Directory in Winnipeg. What a relief it was to our local situation is shown by the fact that instead of fifty on call per day from the previously mentioned hospital; as in November 1936, the same month the following year there were but twenty.154
Within three years nursing leaders wartime nursing shortages were causing nursing leaders to view this out-migration with less enthusiasm.\textsuperscript{155}

The most troubling impact of unemployment however was the degree to which nurses were being underpaid, or unpaid for their labour. In 1954 Vera Chapman received a letter from a former patient containing the $10.00 the patient had owed for work Chapman performed in 1933.\textsuperscript{156} Like Chapman, many nurses could find jobs, but had trouble getting paid. A survey conducted between 1933 and 1935 among Manitoba private duty nurses revealed that "thirty-two percent. of the nurses in the province of Manitoba have not received the full fee for one case during the past two years", and two-hundred and thirty-one cases were nursed with no remuneration.\textsuperscript{157} Such documentation flew in the face of the standard fees established by MARN's Central Directory Committee. That standard included the basic $5.00 for twelve-hour duty, $6.00 for twenty-four hour duty, and travelling expenses for out of town work.\textsuperscript{158} When student nurse Violet Erickson included in her assignment on "Organizations" the following suggestion:

...in specialing $5.00 a day seems alot [sic] for the patient to pay and alot [sic] of people hesitate & decide not to have a special nurse. If the price was $3.50 -$4.00 more people would consider having a special nurse & this would give more work & the nurses probably would be just as far ahead with money.\textsuperscript{159}
she did not appreciate that by the time she graduated, she might have difficulty charging at all for her twelve hours of work.

Given these conditions private duty nurses accepted the "temporary" measure of "general duty" hospital employment. The counterbalancing forces of patient demand for subsidized "public" hospital care, pressure from nurses to reduce the number of student nurses, and employment schemes for graduate nurses combined to emphasize institutional employment of graduate nurses. While Census officials seemed somewhat baffled by the transformation occurring in the occupation, comparative figures from 1931, 1936 and 1941 do indicate the nature of this shift to hospital employment. In 1931 only 390 graduate nurses were considered "wage-earners" by the Dominion Bureau of Statistics. By 1936 that number had grown to 698. By 1941 improved occupational options for women, in nursing as elsewhere had led to a slight reduction in wage-earning nurses, numbering 615 that year. Still, the percentage of Winnipeg's graduate nurses categorized as wage-earning, rather than self-employed on their "own account", rose from 53% of all graduate nurses in the 1931 Census, to 83% in the 1936 and 84% in the 1941.

The case study of the relationship between nurses, hospitals and the private market in Winnipeg locates the national nursing crisis of the interwar years within the regional economies provoking that crisis. This case study emphasizes the socio-economic
structures which characterized the workplace experiences of the third generation of graduate nurses, and highlights the agency of nurses themselves in influencing the health care system. Large urban hospitals such as the Winnipeg General Hospital served as important determinants of the size and composition of the nursing workforce. However, institutions both large and small were reliant to some degree upon the labour pool of educated women seeking skilled training, and thus hospital administrators struggled to maintain the reputation of their institutions. Rural women from Manitoba and beyond provided an important supplement to the urban labour market. Regardless of rural or urban status, or class background women were attracted to nursing because of the skilled training it offered. Such training might never be used after marriage, but possessing graduate and Registered nurse credentials permitted women the confidence and authority to support themselves within or outside of marriage. Most graduates preferred private duty, even as private care followed patients into institutions. The national crisis in both home and hospital private care created and accentuated divisions among nurses, outmigration from the Prairie region, and the undercutting of wage standards. In Winnipeg, as elsewhere, hospital employment of graduates emerged as a temporary solution, one which proved timely. Federal financing of institutional services during the Second World War solved some of the workplace issues which had haunted nurses since 1918. Yet other issues, such as control over the value of nursing work, were
submerged, only to resurface two generations later. Most Canadian nurses struggled through the interwar decades searching for ways to claim status and value as skilled service workers, a self-definition rooted in the content if not the structure of nursing care.
Notes

1 MARN, "Binoculars Lifted!" (MARN, May, 1948), p. 1. Advocating greater nursing participation in the social planning of post-war Canada this report began "In memory, most nurses can recall the time when, upon graduation, the great majority of nurses tripped down an alluring path into a garden of great adventure in private duty nursing."


4 The Winnipeg General Hospital alone contributed 118 graduate nurses to active service, the largest number of nurses from a single Canadian institution. WGH Alumnae Journal, June 1921, (WGHAA).

5 By 1921, the year the Dominion Bureau of Statistics (DBS) reported for the first time that as many Canadians lived in urban settings as rural, Manitoba was the most highly urbanized of the Prairie Provinces with 6 of 10 citizens living in urban districts. See John Herd Thompson and Allen Seager's discussion of the "generous" definition of "urban" and the process of urbanization in the twentieth century. Thompson and Seager Canada 1922-1939 Decades of Discord, (Toronto: McClelland and Stewart Limited, 1985) pp. 2-4, 96-103.
As would befit the "Gateway to the West" commerce (including trade and merchandising) and transportation occupied 22.1 and 13.7 per cent respectively of Winnipeg's working population, while construction workers (17.2%) nearly equalled those in manufacturing (17.6%) during the pre-World War I building boom. From, Ruben Bellan, Winnipeg First Century: An Economic History (Winnipeg, Queenston House Publishing Co. Ltd., 1978) p. 115.


Population peaked in 1915, and hovered around the 200,000 mark until the 1930's when it began a slow but steady climb. Artibise, Winnipeg: A Social History.


10 In his "popular" history of working people in Manitoba, Doug Smith has termed the 1920s "Dress Rehearsal for a Depression", Doug Smith, Let Us Rise: A History of the Manitoba Labour Movement (Vancouver: New Star Books, 1985). See also John Herd Thompson with Allen Seager, Canada 1922-1939: Decades of Discord for a discussion of the uncertainty and uneven growth which characterized the Canadian economy in the interwar decades.

12 DBS, Vital Statistics, 1929 and 1939 reported that the infant mortality per one thousand live births for the 1921-1929 period was 62.4 for Winnipeg, and 78.3 for the province. By the latter half of the 1930s those figures had reduced to 38 and 59.8 respectively.
13 Ibid. In 1921 Winnipeg's infant mortality rate was measured as 77.5, compared to 90.4 for Toronto and 56.3 for Vancouver. By 1929 each city reported similar degrees of improvement, respectively claiming 56.2, 80.3, and 41.1 deaths per one thousand live births. By 1930 the same differential was still in place, with Winnipeg reporting 30, Toronto 43, and Vancouver 25.


16 City of Winnipeg, Municipal Annual Reports, 1920-1939.

17 To "correct" the death rate the number of deaths occurring within 36 hours of admission to the municipal hospitals was subtracted from the total deaths occurring in the hospitals. Ibid.


20 DBS, Census of Canada, 1931 lists 122 doctors in Calgary, 145 in Edmonton, 79 in Regina, and 62 in Saskatoon.

21 This was followed by the University of Saskatoon, and finally the University of British Columbia in 1950.

22 For instance, a May 1936 editorial in the Manitoba Medical Association Review (MMAR) chronicled the work of the Legislative Committee of Twelve, which, representing the Manitoba medical community, worked to ensure that the 1936 Provincial Bill to license chiropractors was defeated by a vote of thirty to thirteen. MMAR, 16, (May 1936). For a discussion of similar strategies employed by the medical profession in Canada's Maritime provinces see, Colin Howell., "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes," Acadiensis, X, no. 1 (1981): pp. 2-22. 's.

23 MMAR, 15 (October 1935).

25 For a discussion of Winnipeg doctors' collective and radical response to municipal medical relief during the early 1930s see, C. David Naylor, "Canada's First Doctors' Strike: Medical Relief in Winnipeg, 1932-4," Canadian Historical Review, LXVII, no. 2 (1986): pp. 151-180. Naylor emphasizes the professional solidarity of Winnipeg doctors "particularly since the work action was maintained over several months in open contravention of the doctors' own ethical code", p. 177.


27 MARN Central Directory Committee Reports, 1922-1940. (MARN Library)

28 WGH Alumnae Association Journal, 1921 (WGHAA); also listed in Henderson's Directory, 1921.

29 See for example, "Social Service Information: Hospitals and Homes" Henderson's Directory 1921 and 1923.
30 See Figure 4.3

31 For example, American College of Surgeons, American and Canadian Hospitals, (Minneapolis: 1936) p. 1359 listed Winnipeg's Misericordia Hospital as "Not for profit...Colored admitted." whether institutions accepted "coloured" patients.

32 See for example, "Social Service Information: Hospitals" Henderson's Directory, 1923 which lists the "investigation and Collection Department of the City of Winnipeg for Public Ward Patients in Hospitals, Established 1910...Object - To investigate the financial ability of persons admitted to the public wards of hospitals coming under the Charities Aid Act of the Province, to pay for treatment therein and to collect from those reported able to pay."

33 DBS, A Directory of the Hospitals in Canada, 1933. (Ottawa: King's Printer).

34 Deer Lodge Hospital listed 200 beds for convalescing veterans. 1931: DBS, A Directory of the Hospitals in Canada.

35 Ibid. In 1931 the Census reported that the 46 hospitals in Manitoba employed 331 graduate nurses and 883 student nurses. DBS, Census, 1931 vol. 9 (Ottawa: King's Printer, 1936).

36 Winnipeg General Hospital, Reports and Accounts, 1920-1939

37 DBS, A Directory of the Hospitals in Canada, 1931; American College of Surgeons, American and Canadian Hospitals, 1933 and 1936.

38 American College of Surgeons, American and Canadian Hospitals, 1936, p. 1360.

39 By 1921 the name had been changed. Henderson's Directory, 1921; see also DBS, A Directory of the Hospitals in Canada, 1931.

40 DBS, A Directory of the Hospitals in Canada, 1935.
41 American College of Surgeons, American and Canadian Hospitals 1936, p. 1359. See also, Frances E. Wagner Eighty Years of Grace: A Brief History of Grace General Hospital, Winnipeg, Manitoba, from 1890 to 1970 (Winnipeg: Grace Hospital, 1970)


43 City of Winnipeg Municipal Annual Reports, 1920-1939. Municipal Hospitals infectious facilities slowly consolidated at the Riverview location.

44 Henderson's Directory, 1923.


46 DBS, A Directory of the Hospitals in Canada, 1931.

47 Henderson's Directory, 1923. As was the case in other Canadian cities, private facilities faced not only financial strain, but also careful surveillance by government agencies enforcing medically-established standards. Some private facilities were taken over by "public" organizations; for example the Mineral Springs Sanatorium was taken over by the Concordia hospital. For a discussion of smaller, private institutions in Vancouver see Margaret W. Andrews, "St. Luke's Home, Vancouver, 1888-1936," Journal of the Canadian Church Historical Society, 24, no. 2 (1982): pp. 90-98; David Chenyan Lai, "From Self-segregation to Integration: The Vicissitudes of Victoria's Chinese Hospital," BC Studies, 80 (Winter 1988-89): pp. 52-68; Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver,


49 WGH House Committee Minutes, April 2, 1923, April 19, 1923.

50 In his research on the discovery of insulin Michael Bliss concludes that the work of Banting, Best, Collip and Macleod "had the greatest meaning...[for]those diabetics whose lives were saved because insulin was discovered in Toronto in 1921-22 and not somewhere else later." However, the WGH dilemma is an important reminder that scientific discovery of a medical technique did not mean immediate availability in the private health care market. Michael Bliss, "The Aetiology of the Discovery of Insulin," in Charles Roland, ed., Health Disease and Medicine: Essays in Canadian History (McMaster University, 1982) p, 344.


52 See Kathryn McPherson, "Nurses and Nursing in Early Twentieth Century Halifax" (M.A. thesis, Dalhousie University, 1982) for a discussion of public health nursing services in Halifax.

53 "The Victorian Order of Nurses", WGH Alumnae Journal, (June 1923), p 9; see also Vera Chapman, interview by author, tape recording, 2 July 1987 for a description of the "mostly middle class" patients served by the VON.

54 Olive Irwin, interview by author, tape recording, 3 August 1988.

55 Ibid. In 1936 the Winnipeg VON attended only 83 obstetrical cases, and 67 confinements, and the MMAR credited this limited number to the increased demand for hospital obstetrical serviced MMAR, 16 (May 1936).
56 Alan Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914*, p 191

57 Ibid, pp. 190-192.

58 Isabella Craig, "Around the City with the Margaret Scott Nursing Mission", *Canadian Nurse*, (April 1926).


62 Dee Dee Rizzo, *Mount Carmel Clinic A History*; see also Anne Ross, interview by author, tape recording, 4 August 1988, for Ross's own story of her career with the Clinic.


64 Alan Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914*, pp. 231-236.

65 Paul Voisey, *Vulcan: The Making of a Prairie Community* (Toronto: University of Toronto Press, 1988) describes the difficulties faced by people in Alberta's agrarian communities in attracting doctors and providing sufficient medical service. He states, "each summer the local newspapers reported dozens of grisly accidents, injuries...deaths sometimes resulted from lack of prompt medical

66 Henderson's Directory, 1923, 1929; American College of Surgeons, American and Canadian Hospitals, 1933.

67 Harvey Agnew, Canadian Hospitals, 1920 to 1970, p. 166.

68 For example, see Henderson's Directory, 1923.


70 DBS, A Directory of Hospitals in Canada, 1934.

71 Henderson's Directory, 1921; American College of Surgeons, American and Canadian Hospitals, lists 610 beds in 1931, and 1936; DBS, A Directory of Hospitals in Canada, 1934 lists 637 in patients at the WGH.

72 "Report of the Superintendent on the Meeting of the American Hospital Association", WGH House Committee, Minutes, 6 September 1921.
73 Ibid.

74 Beryl Seeman, interview by author, tape recording, 8 July 1987.

75 Calculated from the American College of Surgeons, *American and Canadian Hospitals*, 1933, for Manitoba Institutions in 1931. Those institutions graduated 245 nurses that year.


78 MARN Board of Directors, Minutes, March 1929.

79 MARN, General Meeting, Minutes, September 6, 1935.


81 Tabulated from MARN Registration Cards, 1918-1939 (MARN Library).

82 See for example, "Senior Lecture Notes" October 1, 1910 - January 16, 1911 (WGHAA Archives); St. Boniface General Hospital School of Nursing, "History", no date (1970?) (St. Boniface General Hospital School of Nursing Archives).

83 WGH House Committee, Minutes, 30 August 1921.


85 For example, MARN, Board of Managers/Directors, Minutes, 30 January, 1931, 29 September, 1933, 26 March, 1934.

86 The degree to which individual nursing superintendents were successful in their bid for autonomy depended upon local conditions. The history of Canadian hospitals is filled with conflicts between
nursing superintendents and their boards of directors. For example, in 1916 nursing superintendent of the VGH, Helen Randal, and four of her senior nursing staff resigned over the refusal of Medical Superintendent Malcolm MacEachern to accept Randal's recommendation for acting nursing superintendent during Randal's leave. To Randal, the action of MacEachern meant "that she had not the support of the Board nor the Superintendent in carrying out the management of her department." VGH Board of Directors, Minutes, April 10, 1916 (VCA Add MSS 320, Series A); see also, Ethel Johns, The Winnipeg General Hospital School of Nursing, 1887-1953 (Winnipeg: Winnipeg General Hospital, 1953) for a discussion of problems betwen superintendents of nursing and the various boards of directors at the WGH.


89 St. Boniface General Hospital School of Nursing, "History", pp. 4, 7, 9.

90 WGH Alumnae Annual, 1928, p. 69.

91 Ibid. Also MARN, "Minimum Curriculum for approved Schools of Nursing in the Province of Manitoba", 1941.

92 Letter, Mary Martin, WGH Superintendent of Nursing to Mary Shepherd, 6 January 1925 (Mary Shepherd Collection).

93 Letter, Mary Martin, WGH Superintendent of Nursing to Mary Shepherd, February, 1925 (Mary Shepherd Collection).

94 Some students with less education still were accepted. For example, in a St. Boniface student who only had grade 9 was not permitted to write RN exams. MARN, however by 1925 the VGH School of Nursing was advertising that "An educational standing of Grade XI or its equivalent is accepted though preference will be given to those having more advanced standing.", WGH School of Nursing Statement, 1924-1925 (Mary Shepherd Collection).
Calculated from MARN Biographical File. Similar numbers were listed for the graduates of rural hospitals. The five graduates from Morden, Dauphin, Brandon Kenora and Souris/Glenwood averaged 23 years at completion of their programs.


Mary Shepherd, interview by author, tape recording, 18 June 1987.

Ibid.

Mable Lytle, interview by author, tape recording, Winnipeg, Manitoba, 30 June, 1987; Olive Irwin, interview by author, tape recording, Winnipeg, Manitoba, 3 August, 1988; Ingibjorg Cross, interview by author, tape recording, Vancouver, British Columbia, 20 July, 1988; Isabel Cameron, interview by author, tape recording, Winnipeg, Manitoba, 1 July, 1987; Grace Parker, interview by author, tape recording, Winnipeg, Manitoba, 25 June, 1987; Anne Ross, interview by author, tape recording, Winnipeg, Manitoba, 4 August, 1988; Beryl Seeman, interview by author, tape recording, Winnipeg, Manitoba, 8 July, 1987


DBS, Census of the Prairie Provinces, 1936. An even greater proportion of student nurses, 85%, fell into the 9-12 years of school category, while another 13% had over 13 years of education.

By the 1940's "personality" was revived as a criteria for nursing schools, this time in the form of psychology. A 1941, a University of Toronto thesis "An Attempt to Select Student Nurses by means of a Battery of Psychosocial Tests" hypothesized that such tests "could be used to identify the applicants most liable to fail the course, or those most apt to be very successful" and would aid superintendents in the selection of new students.

WGH, Reports and Accounts, 1931, p 4.
104 Ibid, 1919 p. 34.
105 Ibid, 1922 p. 34.

107 For example, in 1918 WGH Superintendent of Nursing reported that only 25% of applicants to the school were from the city of Winnipeg: City applicants 101, Manitoba (exclusive of the city) 138, Eastern Provinces 40, Western Provinces, 111, United States 23, Ibid, 1918, p. 27.

108 Tabulated from interviews with retired "third generation" WGH graduates, see "Nurses and their Work: Oral Histories of Nursing in Winnipeg, 1920-1939" PAM.

109 Calculated from WGHAA, Blue and White, 1924-1939. Most years, the yearbook included under their photographs the hometowns of graduates.


111 Paul Voisey discovered that the sex ratio "never balanced completely, not in new rural communities like Vulcan, not even in the century-old ones of Ontario...neither rural frontiers nor settled rural areas anywhere offered single women many opportunities to earn a living" and despite small town demand for teachers, secretaries, store clerks, hotel waitresses, and telephone operators, between 1931 and 1936 females "constituted more than half of those leaving the Vulcan area...while males accounted for over half of those entering it....More often than men, single women fled to cities, where a variety of options abounded." Voisey, Vulcan, p. 20.
112 Florence Polson's father was employee of the general store in the Icelandic community of Gimli. Florence Polson, interview by author, tape recording, Winnipeg, Manitoba, 1 July 1987; Mary Shepherd, tape recording; Mary Duncan, interview by author, tape recording, Winnipeg, Manitoba, 22 June 1987; Harriet Pentland, interview by author, tape recording, Winnipeg, Manitoba, 13 June 1986.

113 Thus Weir's findings for the significant presence of women from agricultural backgrounds may have been even more conclusive had he tabulated his results by urban/rural locale. See, George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932).

114 See chapter 6 for an example of an instance when students' contacts in the community may have encouraged students at a Guelph hospital to take strike action.

115 This story is recounted in F. Madeline Perry, *BGH 100: A History of the Brandon General Hospital 1883-1983* (Brandon: The Brandon General Hospital, 1983) p. 73. Darrach was married to Persis S. Darrach (nee Johnson) former Superintendent of Nurses at BGH, nursing sister decorated for her service in WWI, and activist in the MARN and CNA. Ibid, p. 71.


117 Beryl Seeman, tape recording.


120 *Henderson's Directory*, 1929-1933.


124 Ingibjorg Cross, tape recording. Cross recalled that she and her teammates were paid five dollars per player when they won a district baseball game. At other sports days she won cash prizes in the various sprints.

125 Jo Mann, tape recording.

126 Vera Chapman, tape recording.

127 Violet McMillan, tape recording.

128 Jo Mann, tape recording; See also Mary Shepherd, ed. "The 1928 Class: 28 Years Later, 1956," (WGHAA Archives), to which graduates of the class of 1928 submitted short life histories. Stories such as that of one graduate who, after a military posting with the Canadian forces, married. She and her husband "set out to make our fortunes on a mink ranch" but when in 1950 "we found ourselves with all our dollar signs on the wrong side of the ledger" she returned to nursing. See also "Biography of Edna Wilson" (no date), (Kathryn McPherson Collection) for the work history of a Dauphin General Hospital graduate of the 1916 class whose husband died suddenly leaving Edna to support her two daughters. This she did, first serving as a superintendent of a small rural hospital, then returning to Regina where she "had no difficulty in securing steady work at the Regina General Hospital and grey Nuns Hospital".


130 Tuberculosis was the most-frequently discussed of the many health ailments afflicting nurses. See E. L. Ross, M.D. Assistant Superintendent, Manitoba Sanatorium, Ninette, "Tuberculosis in Nurses: A Study of the Disease in Sixty Nurses Admitted to the
Manitoba Sanatorium," Canadian Nurse (June 1930) pp.283-289 for a study which concluded that at the current rate "one out of every seventeen young women entering upon training as nurses can be expected to develop tuberculosis...all data we have show that tuberculosis is relatively much more common among nurses in hospitals than nurses out of hospitals." p 283.

131 Miss McGillvary was one of the WGH personalities who appeared in many of the oral histories of WGH grads. Data pertaining to her personal commitments was gained from her niece, a friend of our family.


133 MARN Central Directory Committee, Report, February 6, 1942.

134 WGH, Reports and Accounts, 1918, p. 37.


136 Ibid, 1925, p. 17.AR.

137 This fact, combined with the frequent rotation of students from "nights" on to "days" and back, explains the imprecise recollections of hospital hours of duty retired nurses demonstrated

138 WGH "Guide for Special Nurses on Duty in the Winnipege General Hospital" December 1912 (PAM, WGH Collection).

139 "Social Service Information Hospitals" Henderson's Directory, 1920. This practice was common in the early twentieth century as both a fund raising measure and an educational feature, see for example K. McPherson, "Nurses and Nursing in Early Twentieth Century Halifax."

140 "Registrars report to MHA and MARN", June 13, 1939, p 5 (MARN Library).

141 WGH, Reports and Accounts, 1926-1938 list the fees from patients paid for costs incurred by Special duty nurses.
142 See for example, Furby Thorolffson, *Notebook* (1924-1927) and Violet Erickson, *Notebook* (1929-1933) (WGHAA Archives) for descriptions of the special domestic work private rooms entailed for student nurses.

143 *Henderson's Directory* agents did not enumerate many private duty nurses that were working in the city. See for example, Violet McMillan, tape recording. According to her interview, in 1931 McMillan was living with "Forbes" and "Darymple" at their suite in "Diana Court", but only the latter two were cited in the 1931 Directory.

144 Tabulated from *Henderson's Directory*, 1930.


146 MARN records alone do not provide an accurate reflection of changes in quantity of employment, since the success of MARN's employment service was linked as much to associational activities as to changes in demand for nurses. These figures therefore reflect changing patient demand for nursing service as well as MARN's organizational success in representing its constituents.

147 These figures are calculated from the MARN Central Directory Committee, *Reports* 1924-1929, and the MARN Registration Cards.


149 Helen Smith, interview by author, Tape recording, 3 August, 1988; Violet McMillan, Tape recording.


151 MARN Central Directory Committee, *Report*, February 6, 1942


153 Ibid, 1936.
154 "Registrar's report to MHA and MARN", June 13, 1939, p. 2-3.

155 See for example, MARN, "Binoculars Lifted!".

156 Vera Chapman, Tape recording.


158 MARN, "Schedule of Rates and Hours for the Members of Manitoba Nurses' Central Directory", 1928 (Mary Shepherd Collection).

159 Violet Erickson, Lecture Notes.

160 DPS, Census 1931, 1941 and Census of the Prairie Provinces, 1936.
Chapter 5
Rituals and Resistance: The Content of Nursing Work

From the administrative reorganization of the nineteenth century to the financial reorganization of post-WWII, events within the hospital had direct impact upon the world of nursing. Developments within the prairie city of Winnipeg exemplified the national pattern whereby institutions influenced the size and composition of the nursing workforce, as well as the conditions staff experienced in the workplace. What has received less contemporary or historical recognition was the significant contribution nurses made to the therapeutic and economic viability of the hospital as it ascended to the dominant locus of medical service. The caring and curing dispensed by nurses, the largest group of hospital patient-care personnel, determined the ability of hospitals to deliver affordable and effective treatment. Prior to the 1940s, when the introduction of antibiotics furnished modern medicine with a powerful weapon against disease and infection, patient health and hospital reputations depended on the prevention of infection through asepsis and antisepsis techniques upon which nurses' entire system of practice was based.¹

While the content of many nursing procedures might not surprise modern health care personnel, and while such detail is recognizable to any nursing alumna, no Canadian study describes the totality of what nurses actually did to and for patients. Many
hospital or professional histories include anecdotal evidence of this nature, and yet, other than prescriptive curriculum guides, an analysis of the range of therapeutic and non-therapeutic services nurses performed does not exist.² This chapter provides that analysis and argues that nursing practice was, by definition, scientific, predicated as it was on a theoretical knowledge and practical application of the germ theory of disease.³ The development of nursing technique paralleled the process whereby scientific theories were incorporated into medical practice, for as the medical profession accepted the germ theory so too did the implementation of aseptic nursing technique become more important. Institutions were charged with the dual responsibility of providing a safe therapeutic environment for patients and training a corps of skilled assistants for medical practitioners. However, given limited funding, these two goals had to be accomplished by minimal supervisory or teaching staff. Borrowing from models offered by military service, religious cloisters, familial relations, and industrial production, hospitals structured their nursing education to groom apprentices in the rituals and routines which constituted nursing technique. In doing so, administrators ensured the therapeutic efficacy, social respectability, and administrative efficiency of hospitals themselves.

Throughout the 1920s and 1930s, hospital nursing school curriculum was designed to drill students in the precise routine for each technique in the six areas of nursing service -- assisting
doctors with medical procedures, performing nursing therapies, delivering personal patient services, cleaning facilities and equipment, performing diagnostic tests, and completing administrative duties. Living and working at the hospital, student nurses discovered that the discipline enforced on the ward was matched by the strict rules regulating leisure time and endorsing feminine decorum. As hospitals such as the Winnipeg General confronted overcrowding and underfunding, administrators attempted, with only moderate success, to further routinize nursing service through industrial models of rationalized production. Yet, the very rituals and routines upon which administrators hoped to increase production also provided nurses with a strong identity as skilled workers and provoked overt and covert forms of resistance to unreasonable medical, administrative or patient demands. Nursing technique served to define and defend their status on the job; it also differentiated nurses from women providing "unskilled" care in the community and provided a set of skills which would facilitate nurses' reentry into paid work, should marriage fail. Whether they continued to work in health services, or left the occupation for marriage and family, nurses retained their identity in ways that other women workers did not. Gender distinguished nurses from doctors, but the scientific skills of aseptic technique differentiated nurses from the rest of their sex.

Like the establishment of scientific theory within medical practice, the integration of aseptic and antiseptic procedures into
nursing care spanned half a century. In the nineteenth century, science had transformed medicine by offering a theoretical and evidential basis for medical practice. European scientists like Koch and Pasteur capitalized upon advances in anatomy and physiology to reconceptualize the cause of human disease. Their research hypothesized that diseases were the product of micro-organisms or germs, which, when allowed to flourish, debilitated the human host. And yet while leading physicians and surgeons increasingly embraced this theory of disease causation, they lacked the curative skills necessary to stop diseases once in progress. The most dramatic interventions developed in the late nineteenth century were in surgery, and even those required the preventive measures offered by antisepsis and asepsis so as to not do more harm than good. Antiseptic procedures, made famous by Scotland's pioneer surgeon Joseph Lister, involved destroying micro-organisms around a wound or incision through the application of an agent such as carbolic acid. The aseptic method, less renowned in medical myth but as significant in practice, was designed to prohibit new sources of infection from invading the already-weakened corporeal state of the patient. Although the scientific principles of the germ theory and antiseptic surgery were established by 1870, complete medical acceptance of them was slow. As Charles Roland established in his study of the introduction of antiseptic surgery in Canada, Canadian doctors were exposed to Listerism via their professional journals within a few months of Lister's original 1867 publication. Yet as
late as 1879, prominent practitioners such as Toronto's Dr. William Canniff were still arguing vociferously against Lister's technique, refusing to abandon the existing "miasmatic" or inorganic theory of disease causation.⁶

The debate within medicine carried over into discussions of the activities of the recently established training schools for nurses. In 1875 the "First Annual Report of The St. Catharines Training School and Nurses' Home" boasted the following combination of old and new theory and practice:

Every possible opportunity is seized to impart instruction of a practical nature in the art of nursing, while teaching will be given in chemistry, sanitary science, popular physiology and anatomy, hygiene and all such branches of the healing art as a nurse ought to be familiarized with....The necessity for such institutions as this, must be obvious to all who have either suffered from disease in their own families and persons, or who have had much experience in the care and management of the sick....All the most brilliant achievements of modern surgery are dependent, to a great extent, upon careful and intelligent nursing, and the obstetrician knows only too well how fearful may be the consequences of ignorance and negligence on the part of attendants in the chamber of accouchement....[The skilled nurse] will likewise, by the proper precautions well recognized in hygiene, avert the evils of contagion or infection, and the spread of disease by noxious miasma....⁷
The confidence with which St. Catharines' heroic Dr. Mack and his nursing administrators connected "the most brilliant achievements of modern surgery" with the miasmatic theory of disease causation reflected the more generalized controversy within medical thought over the validity of Pasteur's assertions regarding the organic basis of disease, his "germ theory". Many nineteenth-century health authorities, including confirmed "sanitationist" Florence Nightingale, did not accept Pasteur's findings, believing instead that disease was caused by the noxious vapours of decaying organic matter, miasma, and that only sanitary reform of water and sewage systems would improve the people's health.

As the nineteenth century drew to a close the germ theory had supplanted the miasmatic theory as the accepted explanation of disease causation, but the sanitationist tendency within medicine continued. For example, as late as the 1890's, the Provincial Board of Health of Manitoba provided residents with "Practical Hints for Checking the Spread of Infectious Diseases And other General Information upon matters of Sanitary Importance." The 54-page pamphlet answered the question "In what way may we most effectually exterminate, or at least, lessen the prevalence of these [infectious] 'diseases?' with the three words "Cleanliness: Isolation. Disinfection." A disinfectant or "germicide" was defined as "an agent which has the power of destroying germ life" as compared to a
deodorant which merely removed offensive odors, or an antiseptic which
retards, prevents or arrests putrefaction, decay or fermentation...may also arrest the
development of the germs of disease but it does not destroy the life of disease germs and
hence cannot be relied upon when such germs are present.11

Antiseptic techniques, which had not yet gained the confidence of
many practitioners, remained of secondary importance to the
traditional sanitationist methods of disinfecting embraced by
Manitoban public health officials.

In order of "usefulness" disinfectants suggested were fire,
steam, dry heat, boiling in water, fresh chlorinated lime, corrosive
sublimate (Mercuric Chloride), carbolic acid, blue stone, chloride of
zinc, solution of chlorinated soda and sulphur fumes (sulphur
dioxide). The pamphlet of "Practical Hints" included a section
instructing Manitobans in techniques "To Disinfect the Persons of
Patients and Nurses".

Wash the whole surface with:
1st, A whole solution of carbolic acid, 1 to 50
of water, Or,
2nd, Corrosive sublimate (Mercuric Chloride)
1 to 1000 of water. 1 drachm [sic] to 1 gallon
soft water. This should only be used under
medical supervision, as it is a powerful
poison. Or,
3rd, Solution of Chlorinated soda,
(Labarraque's solution) 1 to 5 of water. Or,
4th, Chlorinated Lime. 6 oz to 1 gall. of water. Nurses should always wash their hands in one of the above solutions immediately after handling the patient or his soiled clothing.¹²

These elaborate instructions for disinfecting not only patients and their attendants but also entire rooms and buildings reflected two facets of the developing system of disease prevention; the incorrect belief that germs could and should be eradicated completely and the public health commitment to collective rather than individual solutions to community health problems. As the Manitoba health officers declared:

So long as municipal authorities allow streets and lanes to remain in the condition they are usually found private individuals can scarcely be blamed for untidiness....No wonder the germs of disease are hard to eradicate, when there are so many hotbeds, as it were, for their propagation.

Only when affluent neighbourhoods were threatened by unsanitary conditions, be they organic or miasmatic in origin, did public health advocates in cities such as Winnipeg gain financial support for their sanitary reforms.¹³

While public health officials promoted domestic disinfection techniques, antiseptic and aseptic techniques were slowly being integrated into the daily practice of Canadian medical and nursing practitioners. In a December 16, 1910 lecture entitled "Contagious and Infectious Diseases", Dr. Pierce informed the Senior Class of the Winnipeg General Hospital School of Nursing that "Bacteriology
explains disease caused by minute organisms," and that this scientific sub-field was relatively young. As one young student nurse interpreted from Dr. Pierce's lecture:

The etiology of disease was determined during the last thirty years. Previous to this there were all kinds of theories....The germ theory, which is now a recognized fact, had no basis in fact until 30 years ago. This theory originated in France, from fermentation and putrification causing growth of plant organisms. It was first applied to animal life by Robt Coke [sic] who proved disease caused by organisms. Since then a large number of diseases have been found to be caused by a specific germ....

Pierce stressed that for each known infectious disease the etiology, pathology, symptoms, and "prophylaxis or prevention" -- all the keywords of modern medical practice -- must be understood, but he and his colleagues remained committed to the usefulness of disinfectants for household practices. For example, to prevent the spread of typhoid the contagious patient's fecal matter was treated with the conventional antiseptic agent, carbolic solution. If circumstances precluded this method, as in "country practice", traditional disinfectants such as "slaked or fresh lime" could be employed, while in all treatment of tubercular patients nurses were to teach patients to "cough into handkerchief. Burn all sputum." Acknowledging the absence of curative treatment for many diseases, the medical lecturer emphasized the importance of immunological preventive techniques, and stressed that while each disease had a
different incubation period, isolation was the most effective means of preventing further spread. Students also learned that "in practically every case the source of infection is due to a carrier"17 and as the germ theory gained widespread acceptance so too did the threat of practitioner-based infection gain recognition. Doctors like Pierce knew that if nurses were responsible for day-to-day patient care, then nurses' role in preventing cross-infection was crucial.

By the 1920s this message was clearly imbedded in nursing theory and practice, as medical and nursing administrators developed specific procedures to meet nursing's mandate. In the years following World War I concern over the eradication of all germs in a house or institution had been replaced by the conviction that as long as patients did not come into direct contact with debilitating micro-organisms, infections would not develop. Medical theory proclaimed:

Infectious diseases are transmitted by actual contact, direct or indirect. Air transmission is so rare that it need not be considered of practical importance, except that doctors and nurses must avoid patients coughing into their faces.18

Work perfected and performed by Winnipeg nurses during the 1920-39 years demonstrated that medical and nursing practice alike relied on a series of aseptic techniques which would prevent "clean" patients from becoming infected during treatment, and would prevent "dirty" or infectious cases from spreading any further. The
"Manual of Technique for the care of Communicable Diseases" published in 1928 by the Winnipeg Municipal Hospitals explained the principles of asepsis to its employees:

Medical asepsis aims to confine each different infection to a physically separate unit. The object of the whole aseptic technique is to prevent the transmission of infection from one unit to another.¹⁹

At Winnipeg's facility for infectious patients, destroying all germs around a patient was considered a less effective preventive strategy than containing the transmission of germs through direct or indirect contact. The standard whereby all employees were "held responsible for the complete and conscientious observance of [aseptic] technique...not only to prevent the spread of infection from patient to patient but to insure employees against contracting infection themselves,"²⁰ was established at all institutions in the city. In particular, nursing staff were assigned the specific duties for creating and preserving aseptic conditions. Achieving asepsis required the proper application of "nursing technique", a precise set of steps completed for each procedure, and nurses were confident that careful application of their technique would ensure the safety of patient and attendant alike. Three years of experience as hospital apprentices, during which time frequent repetition facilitated nurses' mastery of the expedient execution of specific tasks, made nurses confident that careful application of their technique would ensure the safety of patient and attendant alike.
Nursing technique is best understood in the context of large teaching hospitals, like the Winnipeg General (WGH), which trained most Canadian nurses. The administrative structure of the WGH, the model of a modern hospital on which other Manitoban institutions based their internal organization, was a hierarchical pyramid with the small corps of administrators at the peak and the large staff of student nurses at the base. From its inception, the hospital was administrated by a male Medical Superintendent and a female matron/ Lady Superintendent/ Superintendent of Nurses. Married women with connections to the WGH, such as the widow of Dr. Colville Brown, a local practitioner, served as the first on-site administrators of the institution. This sexual division of labour was refined in the late nineteenth-century as graduates of the Nightingale system appropriated hospital administrative positions throughout North America and Britain. Thus in 1891 Matron Brown was replaced by Miss Margaret Laidlaw, and unmarried career woman and a graduate of the WGH's newly established training school. As the first formally trained nursing supervisor, Laidlaw's term lasted only two years, after which a series of women assumed the helm for periods ranging from one to nine years, until 1944 when Bertha C. Pullen of Chicago's renowned University Hospital took on the task for eleven full years. The thirteen women who served as superintendents from 1891-1943 averaged four years, with a mean of 3.82 years. During the first four decades of the WGH's history, the Medical Superintendents demonstrated even higher turnover, no
one doctor serving longer than five years. This changed in 1919 when Dr. G. F. Stephens took charge. The value of his twenty-one-year tenure through the difficult interwar years was acknowledged by peers such as Superintendent of Nursing Catherine Lynch.

When it was necessary for us to reduce graduate staff and when each year our equipment became a little less serviceable, he gave us the courage to go on.

Stephens' persistence through adversity as a medical administrator won WGH stability as well as leadership within the Canadian hospital community.

Together, the medical and nursing superintendents oversaw the daily functioning of the institution's patient-care personnel. Three types of personnel -- orderlies, doctors and nurses -- shared therapeutic duties. Orderlies could be called upon by either doctors or nurses to lift, transport or restrain patients, and to provide specific services such as catheterization and bathing for male patients. The small force of resident doctors provided emergency services, and attended patients housed on the private wards. Throughout most of his rule, Medical Superintendent Stephens delegated responsibility for services such as Pathology, Anesthesia, Records, Medicine and Surgery to his staff of four MDs. These medical services were augmented by interns from the University of Manitoba Medical School completing their training through practical experience on the wards. Joining them on the wards were the
attending staff of doctors who donated their services to the public wards free of charge, as well as the many private practitioners monitoring the progress of the patients they had admitted to the hospital. Assisting these medical practitioners were the student and staff nurses employed by the hospital, and the graduate nurses "specialing" private patients. With the exception of specific tasks assigned to male orderlies, all non-medical patient services and ward duties were performed by student or graduate nurses. Kitchen, laundry, cleaning and maintenance staff were all central to the daily routine of the hospital and consumed much administrative attention, but, like their counterparts in most Canadian hospitals, domestic workers at the WGH were not permitted any direct contact with patients. Similarly, office personnel interacted with patients and their families only upon admission and discharge.

Two systems structured relations among the patient-care personnel at WGH. First, a sex-segregated distribution of power assigned responsibility for all female staff to the nursing superintendent, while the medical superintendent oversaw the activity of male doctors and orderlies. Between 1890 and 1940 no male nurses were hired by the WGH or enrolled in the training program, nor were female orderlies employed. Within each pyramid of authority, practitioners deferred to the directives of their superiors, and tasks were assigned according to hierarchical status. At the bottom of the nursing hierarchy were the probationers, new recruits to the hospital training program.
"Probies" who survived the first six months were "capped" and completed their first year at the WGH as Juniors. Intermediate and then Senior status was accompanied by greater responsibility on the wards, culminating with posting as "charge nurse" responsible for supervising the daily tasks of less-experienced students. Graduate nurses supervised and instructed student staff, and assisted the nursing superintendent with her many administrative tasks. A similar vertical differentiation existed among male staff, orderlies deferring to interns, who claimed less authority than resident staff, or the medical superintendent. Members of the two hierarchies communicated through the symbolic parents of the institution, the medical and nursing superintendents. If a doctor had a complaint about a nurse, it was reported to the medical superintendent who communicated the complaint to the nursing superintendent who in turn disciplined the offending staff member.²⁶

Like familial relations, however, this sexual-division of authority was also characterized by unequal distribution of power.²⁷ All nurses, regardless of status, deferred to all doctors. This was not surprising since medical authority, in both hospital and society, was codified in law. Medical legislative authority asserted that only licensed doctors could practice medicine; practicing medicine included not only the right to diagnose, prescribe and perform specific treatments, but also to define what responsibilities and authority could be assumed by other health care practitioners. Thus, medical control over hospital nursing was an extension of the
broader legal authority doctors possessed. At the Winnipeg General doctors acted out their power at a number of levels. Administratively the highest executive position in the hospital, the medical superintendent, was filled by an MD. As well, day to day operations of the WGH were dictated by the doctors serving on the House Committee. That committee determined nursing salaries and staff size, adjudicated student discipline meted out by nursing supervisors, and evaluated the quality of nursing care. Medical surveillance over WGH nursing services was illustrated in an October 1928 House Committee discussion in which

Dr. Hunter expressed the opinion that there had been a general improvement [in hospital nursing] in the past six months... Dr. Young felt that the attention and individual effort are decidedly improved, as well as ward discipline... Dr. Prowse... considered the situation fairly satisfactory and felt that there were a number of difficulties... which could be... settled by a personal interview with the Superintendent of Nurses. Dr. Gardner concurred...28

The experiences of nursing superintendents at other Canadian hospitals confirmed that such medical supervision of nursing services was the rule, rather than the exception. For example, in 1916 Vancouver General Hospital superintendent Helen Randal, and four members of her senior staff resigned... they were protesting the House Committee's decision to support the medical superintendent's decision regarding Randal's temporary replacement. Randal was
taking a short leave of absence and had recommended the nurse to replace her. Randal informed the Board that as her recommendations had not been accepted and that an appointment had been made of which she could not approve, she had decided to resign, stating incidentally that she considered that she had not the support of the Board nor the Superintendent in carrying out the management of her department.29

Without further discussion, the Board accepted her resignation. Randal's experience revealed the limits of the nursing superintendent's authority within the parameters of the larger patriarchal, medically dominated, administrative structure. Superintendent MacEachern's power relations were manifest in ways that contravened the dictates of social etiquette. Nurses were expected to stand "at attention" in the presence of all physicians and surgeons, walk behind and never in front of medical practitioners, and if necessary, get off the elevators to make room for doctors.30 In the words of a 1928 graduate, doctors "came first, last and all the time."31 The strict discipline defining interpersonal relations on the wards served as a mutually reinforcing model for the stringent routine defining therapeutic and administrative nursing responsibilities.

Administrative, medical and interpersonal structures were symbolized in the nurses' uniforms. Uniforms worn by nurses at the WGH resembled those worn at most other Canadian hospitals, not
only in design but also in function. Uniforms defined nurses' status on the wards and indicated that a nurse was on duty. Throughout the three years one could tell by a nurse's appearance what class year she was in, according to the "language" of the uniform. Each slight alteration to the uniform corresponded to the work being performed at each stage. The basic unit of student apparel was a blue underdress with a fitted bodice which buttoned up the front and a full skirt which had to measure a certain distance, eight or twelve inches, off the floor. Students wore black oxford shoes, black cotton stockings, and a white starched collar which fastened onto the uniform bodice with collar buttons. Probationers beginning their apprenticeship wore over their blue underdress a white half-apron tied at the back with the long pointed ties hanging out down the back. Probationers making the successful transition to Junior status were "capped" at a short but serious ceremony in the Nurses' Home. Mary Duncan recalled that "[capping] was quite a ceremony, the superintendent officiated at that, she placed the cap on your head... and she also spoke about the meaning of it and the responsibility and all the rest of it." With the cap, which signified acceptance into the school, went a bib to extend the apron over the top half of the blue dress as well as two soft cuffs which extended from wrist to elbows over the long sleeves of the blue underdress. Students were now dressed for work, as the white apron, bib and cuffs, all bleachable, served as protectors of uniform and body.
In students' third year further adjustments to the uniform reflected their senior status and the attendant increased administrative and decreased personal service components of daily practice. The long soft cuffs were replaced by shorter stiff ones, and the ties of the uniform no longer hung down the back of the skirt, but rather were crossed at the back and pinned in place. Senior nurses in charge of a ward were identified by the black velvet band they wore on their cap. Upon graduation nurses received their school pin, and began to wear white uniforms, underdresses, stockings and shoes as well as the ever-present cap and the true symbol of graduate status, the pin. The symbolic inversion of traditional female imagery, wherein the colour white signified nurses' workplace experience rather than a bride's sexual inexperience, was reinforced by the elaborate graduation ceremonies sponsored by training schools and alumnae across the Dominion.

The basis of nursing technique was established in students' theoretical and practical instruction and supervision received in the hospital setting. All nurses shared the rituals and routine of hospital training programs before moving on to various occupational sub-sectors in which they applied the appropriate skills selected from their repertoire. This repertoire was learned during hospital apprenticeship, first in the classroom, then on the ward, with the level of responsibility and difficulty increasing as the students advanced. Novices were generally supervised the first time they
performed a procedure, and follow-up inspections were routine. However, the low ratio of supervisors to students meant that, for daily reference and reminder, the latter relied less on their instructors than on their classroom notes -- transcribed to the "little red books" which students always carried deep in the pockets of their long blue skirts.38

It has been the survival of these little red books, retrieved from the backrooms and boxes of interview participants, which facilitates analysis of nursing technique. The following excerpt (Figure 5.1) from Myrtle Bowman's (WGH Class of 1931) hand-printed notebook "Preparation of Hands for Aseptic Treatment Procedure" illustrates the nature of this source. 39
Figure 5.1
Excerpt from Myrtle Bowman, Notebook, 1928-1931

Preparation of Hands for Aseptic Treatment
Procedure:
1. Always use a watch.
2. Roll sleeves securely 2" above elbows.
3. Turn on both taps.
4. Wash hands and arms.
5. Scrub hands and arms with brush for 3 minutes. Give special care to nails, creases at wrist and between fingers.
6. Rinse.
7. Scrub again 2 minutes.
8. Rinse.
9. During whole procedure arms must be held well out from the body, 2 hands up so that water will drip from elbows.
10. Hands to be left moist, palms together and well up above waist line to the side.

Care of the external genitals.
Necessary Articles:
1. Tray containing:
   - A sterile pitcher
   - A sterile towel containing a sterile water.
Each task learned, with its "Purpose", "Necessary Articles" and "Procedures", was carefully reprinted from lecture notes into the handbook. It is not clear how often nurses referred to their personal reference guide. One retired nurse, who had kept both her own red book and that of her sister who had died of tuberculosis five years after her graduation, confessed laughingly that although she faithfully carried her book with her on the wards, the routines of each task had been drilled into them so effectively that their printed reminders were unnecessary.

Nor is it possible to document, with this or any other source, the frequency with which nurses performed specific tasks. Two factors have limited available records of nursing practice. First, most nursing administrators had neither the time nor resources both to supervise and to document the work of nursing personnel. Secondly, when such sources were created, limited institutional storage facilities led to the destruction of many hospital records. Only a rare person like Mary Shepherd, WGH Graduate and long-time Nursing Superintendent at Winnipeg's Municipal Hospitals, who salvaged for personal and sentimental value records of her 3-month training at the King George before acting upon orders to burn old staff records, was able to preserve records of her experience and to document that sometimes such records were created. Of necessity, the little red notebooks together with oral interviews with retired
WGH Graduates provide a unique and important vehicle through which to assess the content of nursing work in the interwar decades.

Six types of nursing activities constituted ward work for hospital apprentices: caring for patients in their beds; completing administrative duties; assisting doctors with, and preparing patients and equipment for, medical treatment; performing tests; cleaning the ward, beds, equipment and supplies; and performing therapeutic nursing procedures. Predictably, it was the latter four categories in which aseptic technique received most emphasis. Administrative routines were structured around the internal organization of the institution, and standards for the personal care of inhabitants ensured the dignity of patients and the respectability of hospital staff and image. In all areas of nursing service ritualistic procedures guaranteed efficient dispensing of prescribed care by a highly unsupervised student staff.

The particular rituals that each nursing procedure entailed served as security against sloppy technique, especially given the minimal supervision provided apprenticing staff. With only one graduate nurse assigned per ward on day duty, and even fewer supervisors on night shift, students performed alone not only therapeutic tasks, but also their many administrative duties. The step-by-step delineation of administrative components included in nurses' education emphasized the organizational efficiency needed
for smooth institutional operation, and thus served as a support for, rather than integral part of, the larger therapeutic goal.

Nurses were required to print neatly all charts and correspondence, and thus the instructors evaluated students' red handbooks and lecture notes as much for neatness as for accurate content. Feedback on 1933 WGH graduate Violet Erickson's first 99-pages indicated that her work was "Much improved. Would be neater underlined in red ink. Very Good." Another WGH graduate, Beryl Seeman, did not expect the Nursing Superintendent Kathleen Ellis to have noticed her amongst the large student population. Years later however, when Seeman had advanced into a supervisory position herself and was reintroduced to Ellis, the latter responded: "I remember you. You had very good printing." The appreciation administrators like Ellis displayed for simple printing skills was appropriate within the hospital's non-mechanized record-keeping system.

A second area of responsibility entrusted to hospital apprentices embraced the various diagnostic tests ordered by medical staff. The routines established resembled those for other nursing procedures, with one exception. Along with the essential scrubbing and assembling of necessary articles, nurses also had to complete the proper documentation identifying the type of sample and to whom it belonged. Urine, stool or sputum samples, and urethral, cervical or throat smears were all sent to the hospital
laboratory for analysis, whereas other tests such as the Wasserman, Dye, Ewald Breakfast, Reigal Meal, and Functional Renal Mosenthal tests were performed on the ward. Results from the laboratory or from ward-administered procedures were printed in the individual patient's chart. For example, to determine the functional capacity of a patient's kidneys Dr. Gilmour's Functional Renal Mosenthal test was ordered. Nurses carefully measured and charted urine collected every two hours from 7 a.m. to 9 p.m. for a one-day period, and then, making sure the patient did not drink anything over night, the nurses ensured that the patient's bladder was emptied again at 7 a.m. the next morning. Each time the patient voided the "specific gravity" of the urine was also noted. Nurses entered all data on the chart, and calculated the total volumes collected. In all diagnostic procedures, nurses participated in or performed the test and as well ensured the precise recording and tabulating of data. Diagnostic tests demanded precise aseptic technique to ensure that data was accurately measured, but also required correct administrative procedures to prevent results from being lost or mixed up.

Assisting medical and surgical personnel involved some of the most precise techniques demanded of nursing staff. Nurses were responsible for preparing patients, and assisting doctors in examinations or treatments performed on a ward, or in a specialty service. To facilitate the efficient use of doctors' time, pre-and post-operative examinations, shavings, dressings, dietary regimens and patient services were all assigned to nursing staff. For
example, aspirations, a technique utilized to remove excess fluid from the pleural cavity, required that the assisting nurse paint with iodine the injection site, drape the patient so that only the treatment area was visible to the doctor, and test apparatus first in the service room and then, once sterilized, again while the doctor was inserting the needle. If all went well neither patient dignity and confidence, nor doctor's time and reputation, was lost.

Specific routines prepared patients for their examination or treatment by physician or surgeon. If necessary the nurse shaved the appropriate region for abdominal, breast, kidney, vaginal, rectal, or neck surgery following the general instructions of lathering parts freely with green soap and water, and holding the straight razor blade "with three fingers and thumb with little finger over projection. Use downward slanting motion." Skin was not to be scratched or nicked, and the area had to be cleaned thoroughly, with ether or alcohol if necessary.51 As well, some treatments needed specific preparatory work such as smears, lavages, diets or, in the case of nose and throat operations, "teeth thoroughly cleansed, hot antiseptic mouth wash given 24 hours previous to operation."52 Both medical and surgical patients might require "draping" to cover all but the necessary body part during examinations or treatments. "Posterior chest", "anterior chest", "lower extremities", "eye", "nasal", "aural", and "throat" drappings might accompany any one of the six main positions in which doctors required patients. The "dorsal recumbant" for vaginal and rectal examinations, the "dorsal
lithotomy" for vaginal, uterine or rectal examinations and difficult or instrumental deliveries, the "Sims" or "left lateral" for vaginal and rectal examinations, minor operations and easy deliveries, the "Trendelenberg" for abdominal operations, the "knee chest" for rectal examinations, and the "standing" were all positions with which nurses had to be familiar.53

Any procedure which created a wound, and therefore a potential site of infection, necessitated the "strictest aseptic technique" from nursing staff.54 The anatomical region receiving the incision first had to be washed with "plenty of hot water and soap" and then the sterile bundle and tray were taken to the bedside. The nurse then screened the patient, unfolded the bundle and, leaving one corner over the contents of the bundle, transferred with sterile forceps the material from the tray to the table. She then draped the patient's bedding appropriately, scrubbed her own hands for five minutes, returned to the patient and draped the anatomical area with a sterile drawsheet and towels, all the while taking care not to contaminate her fingers. She scrubbed the anatomical area three times with sponges appended to forceps, first using green soap and water, then ether, then alcohol, and finally applied a sterile towel or dressing and bandaged it in place. By carefully following this procedure nurses created a sterile region in which surgeons made their incision. Injections or infusions -- intravenous, subcutaneous or Bartlett -- were performed by medical staff members, and accompanying nursing procedures ensured the availability of sterile
equipment within the sterile field of the appropriate tray and/or bundle.\textsuperscript{55}

Surgical procedures such as Lumbar Punctures, Aspirations and Paracentesis required specific sets of aseptic instruments and dressings, all prepared and maintained in a sterile field.\textsuperscript{56} Nursing preparations for Paracentesis, a method to drain off fluid collected in the abdomen, exemplified the precision expected of staff. The nurse collected the necessary unsterile articles such as a Mackintosh\textsuperscript{57} and cover, and a stimulant. Wearing sterilized rubber gloves, the following supplies and dressing tray were prepared:

- Trochar and anula with tubing SOS
- Scalpel and probe
- Sponges
- Dressing, Iodine, Alcohol
- 2 towels
- Medicine glass
- Hypo syringe & 2 needles, basin\textsuperscript{58}

Before the doctor arrived the necessary body hair was shaved, the patient was asked to void, and was then placed in position, either on a backrest, or on the edge of a bed with feet resting on two chairs and back supported by firmly-secured pillows. A sterile binder was applied to expose the abdomen, and once the doctor arrived the nurse was required to: "Watch pulse and give stimulant SOS. Chart on fever sheet in red. Chart in red in treatment column: Amount and character of fluid obtained."\textsuperscript{59} Nursing notes emphasized that "strictest aseptic technique is necessary."\textsuperscript{60}
After operations surgeons visited their patients on the ward, performing at least the first post-operative dressing. For these visits nurses prepared sterile dressing trays, which, provided the sterile field of the tray was not broken, maintained the aseptic conditions during the post-operative phase of treatment. Nurses took great pride in the precise execution of such techniques. One WGH veteran insisted that she only had one post-operative infection, and even then she suspected the surgeon to have been the culprit who "broke" the sterile field of her dressing tray.61

Other prescribed treatments were assigned to nursing personnel to perform without direct medical supervision, and during the interwar years the formal distinction between medical and nursing tasks remained fairly consistent. For example, the first few post-operative dressings were applied by doctors, whereafter nurses changed dressings and monitored the healing process.62 Some permanent transference of medical tasks to nursing personnel did occur, but unlike the dramatic changes in nursing practice which intern shortages during World War II provoked,63 nurses only assumed medical duties informally during the 1920s and 1930s.

This informal assumption of medical duties by nurses occurred most frequently when caring for obstetrical patients. The increase in the number of babies born at WGH was typical of the pattern occurring in all Canadian cities.64 Obstetrical patients were housed on the maternity ward until they went into labour, at which time
they were moved to the "case room" for the delivery, with the exception of Caesarian sections performed in the operating room. Nurses assisted interns or private practitioners to manage the birth, and then provided post-partum care for mother and child back on the ward. Students also assisted with many home births during their apprenticeship with the Margaret Scott Mission, or the Victorian Order of Nurses (VON). In both home and hospital nurses were never certain that medical assistance would arrive on time. At the WGH, enemas were commonly given to parturient women as a natural method to induce labour, but this often had more rapid effects than predicted. Isabel Cameron recalled that "they expected the doctor would be there, but maternity work is very uncertain you never know exactly when it will be." This uncertainty led her classmate Mabel Sharp to rephrase the song "we're always blowing bubbles in the air" and sing instead "we're always having babies in the bed." When interns did not get called in time, maternity ward and home deliveries were performed by nurses. Nurses were very conscious of such possibilities, and many considered their maternity training inadequate. Isabel Cameron knew enough to slap a newborn she had just delivered, but that was all she knew. Olive Irwin regretted not receiving better obstetrical instruction when as a VON nurse she had to deliver alone a baby with its umbilical cord wrapped around its neck. Curriculum guides prepared by the Canadian Nurses Association supported the oral testimony of these WGH trained nurses. The 1936 CNA Proposed Curriculum for Schools of Nursing in
Canada suggested 30-40 hours of obstetrical training for nurses in their second and third years, as compared with 35-45 hours in "Community health and social needs" and 40-50 hours in "Pediatrics", subjects much less likely to involve life and death decisions. During the hours devoted to maternity care in the proposed curriculum, pre- and post-natal care of mother and infant predominated, and obstetrical nursing lectures were designed to teach students "the importance of medical supervision throughout the maternity cycle, and of the need for instruction by the physician and nurse during this entire period." This interwar emphasis on medical supervision and nursing instruction contrasted with lecture notes taken by a WGH student nurse in 1910, wherein detail on the management of labour, both normal and one with complications, was provided for nurses. The process whereby maternity instruction shifted from management of labour and the delivery process itself, to pre- and post-natal instruction and care requires further investigation, but the effect of this shift was that interwar nurses felt ill-prepared for their informal but nonetheless substantial obstetrical responsibilities.

In most other fields, the theoretical differentiation between nursing and medical responsibilities was affirmed in practice. Therapeutic nursing duties were delineated for nursing staff in the same method as those performed in concert with doctors. Nursing procedures were categorized by instructors into ten general groups: counterirritants, medications, enemata, enema, douches, lavages,
drips, irrigation and installations, inhalations, and catheterization. Counter-irritants -- a range of poultices, packs, stupes, and fomentations which were placed on the diseased or infected area -- loomed large in the memories of retired nurses. For patients on the medical wards, mustard plasters and linseed poultices were commonly prescribed.73 Nurses spread either a combination of mustard and flour, or hot linseed, between two cloths and placed it on the appropriate anatomical region, such as the chest for pneumonia victims, for a specific length of time. Once heated, linseed maintained its temperature for a relatively long time and required little further attention, whereas mustard provided its own heat, but had to be monitored very carefully to prevent it from burning a patient. Violet McMillan was well aware when applying mustard plasters that "if you burned a hole in someone you might as well pack your bags and go home right then."74

On either medical or surgical services, real or threatened sites of infection usually resulted in fomentations being prescribed.75 Beryl Seeman described the procedure for one of the most frequently performed nursing tasks.

Preparing fomentations, that was really something and we used a lot of them in those days because of course this was long before even the sulfas were thought of. We had pieces of blankets that were wrapped in a linen holder and these were heated on an element with the ends of the holder on the outside of the basin and when it was time to put on the foment we wrung it dry by the dry ends of the
holder....We had a basin on top to keep the foments warm and you took that, put the foments in, took it to the patient, took the old one off, put the new one on being careful not to burn the patient, tied him up, and put the old foment in the wringer for next time. And when you had to put on sterile foments that was really neat... because you had to have a piece of gauze cooked in this water with the foment inside the sterile foment and you had to have a pair of forceps clamped onto the outside of the holder, the piece of cloth you know.76

As students advanced through their training, procedures which seemed miraculous at first became integrated into standard practice. Seeman recalled:

As a probie I used to envy the junior nurses when they would wring these foments because I thought those forceps were kept there by a neat twist of the wrist you know and I was very disillusioned when I learned that they were just plain clamped on.77

Procedures such as foments remained central to nurses' therapeutic repertoire throughout the interwar years. Other methods of fighting infection such as leeching were taught, but less frequently used.

In an article by Winnipeg General's most famous alumna, Ethel Johns described her experience with one of medicine's more infamous techniques.

One night in the eye and ear ward, I was hurrying down the corridor to do the two o'clock treatments, when, to my horror, on the corrugated matting outside the door of the
eye and ear operating room, I saw three leeches approaching in hideous loops. I knew they were to be applied to an incipient mastoid in the morning, and here they were, having escaped from their gauze covered jar, making for the front door and liberty. Now to me a leech is as much to be feared as a boa constrictor. Did I quail? No; I got a long pair of dressing forceps and tried force. The leeches stretched in a sickening manner, but remained adherent, firmly adherent, to the matting. I tempted them with test tubes of milk. They scorned me. At last the house surgeon came along. That dauntless youth moistened his fingers with milk, the leeches twined lovingly round them and allowed themselves to be restored without a struggle to their jar, on the top of which I placed a dinner plate and a ten-pound weight so as to keep them within bounds for the rest of the night. They looked somewhat battered - my efforts with the forceps accounted for that - but their appetite the next morning was unimpaired. True, the attending otologist commented on their scars, but was assured by my brave champion that they had "probably been fighting during the night." I have never forgotten that intern. I never will.78

Leeches remained a formal part of the hospital therapeutics until at least 1928. Bowman entered the following instructions in her 1925-28 red book:

There are two kinds of leeches, American and Swedish. Swedish is the best. It will take 1 z [sic] of blood. American will take only zl [sic]. Kept in fresh clean water with sand in the bottom of the container. To apply: Cleanse skin with unscented soap. Place leech in test tube head uppermost. Place on skin. Do not
leave patient as leech may crawl into nostrils or ears. If leech does not bite moisten skin with milk or prick skin till it bleeds a little. Do not handle leech too much or it will not bite. To remove leech before it is finished feeding, sprinkle it with salt. Do not use leech twice.79

However, no mate to Johns' humourous tale was recounted by graduates of the 1920s and 1930s. Foments and "antiseptic baths" in saline solution replaced leeching as the standard nursing treatment to relieve inflammation and to check infection.80

During the 1920s and 1930s very few changes occurred in the kinds of drugs nurses administered. Most medications were for pain, such as morphine and codeine, and were prescribed by doctors according to strength and frequency. To administer daily medications, a senior nurse set up a medicine tray well supplied with glasses, a pitcher of iced water and the correct medicine tickets. Red, pink, yellow, or blue tickets, either whole or with one corner clipped off, indicated the frequency of administration, every 2, 3, 4, 6 or 12 hours, or 20 minutes after or 20 minutes before meals. A white ticket signified medication to be given at bed time, and a white ticket with a corner missing indicated early morning administration. Marking white tickets with red ink was also used to indicate any other intervals at which medications were to be given. Once the appropriate tickets were set up on the tray, medicines were measured in a glass according to the ticket instructions and the glass remained there until handed to the patient. When the patient
received her/his prescribed quantity the ticket was turned upside down. "with blank side upper most" and the glass replaced. Nurses were instructed to hand personally the glass to the patient and witness the consumption of its contents; "Never allow one patient to hand medicine to another patient...never leave the medicine by the bed side."81

Some medicines were injected subcutaneously rather than swallowed. Nurses prepared for hypodermic injections by setting up a small tray with the medication, a sterile jar with alcohol and sterile sponges, one jar containing the needles, another with the alcohol and hypodermic syringe, a small bottle of alcohol and one of sterile water, an alcohol lamp and spoon, and matches. The seventeen-step process occurred as follows:

1. Have medication ready
2. Test your needle
3. Place needle with stilette in spoon and cover with water
4. Boil over lamp 2 min
5. Place cover over wick
6. Rinse out barrel of syringe
7. Draw amount of water required into syringe
8. Discard water remaining in spoon
9. Attach needle to syringe and remove stilette
10. Place tablets on spoon and dissolve [sic] with water in syringe
11. Draw prepared fluid into syringe, taking up last drop
12. Expel air from syringe
13. Pick up sponge on point of needle and replace tray in cupboard
14. Cleanse the area, make a cushion of flesh and insert quickly.
15. Withdraw slightly and insert fluid slowly.
16. Withdraw needle quickly, massage area gently with a circular motion.
17. Chart time, medication and initials immediately after giving drug, and mark off in order book.82

The hypodermic example is an important one, for here the relationship between the specific therapeutic technique and the regime for non-therapeutic duties is illuminated. Not only did nurses depend on the aseptic technique of the injection itself, they also relied on the aseptic preparation of basic ward equipment such as jars and water. The step by step procedures involved in the domestic tasks of ward cleaning and maintenance take on new importance when seen as part of a larger system of asepsis for which nurses were responsible.

The maintenance of the ward and equipment were the first series of tasks taught to nursing students. While this often involved simply cleaning the supply room -- a task students often claimed they were doing when a midnight nap was required -- it also included sterilizing the many medical appliances utilized in the era before disposable supplies. Rubber gloves for instance had to be soaked in a 2% lysol solution for twenty minutes, washed, and rinsed with hot then cold water, and finally dropped in boiling water for three minutes. If being boiled for sterilization, gloves had to be covered with water and weighted down, dried inside and out,
examined for punctures, and unless requiring repair were then powdered and wrapped for transfer to the autoclave. Silk Guyon Catheters were damaged by Lysol or boiling and thus required disinfecting in "Bichloride of Mercury 1/1000 or in Formalin 1/2%" followed by rinsing with sterile cold water before using. Other rubber articles - Mackintoshes, medicine droppers, duodenal, stomach and rectal tubes and catheters -- and glassware all demanded specific regimens for cleaning and storing.83

Not only did the contents of each ward require attention, but nurses were also responsible for cleaning and organizing the ward itself. Following the discharge of each patient a particular regimen was followed according to the type of ward and patient. The discharge of a clean case prompted the assigned nurse to gather a whisk, a basin of hot lysol water and a dish containing brown soap and skewer. She stripped the bed84 and mattress cover, whisked the mattress and pillows, placed them and the blankets to air "in sunshine if possible for one hour," scrubbed the bed using the skewer for the coils, and washed down the table and chair with the Lysol solution. In the service room, the Mackintosh was soaked for 20 minutes in a 2% Lysol solution. Next fresh linen, Mackintosh and mattress cover were taken to the bed for its reconstruction. Upon this stern foundation was built the system of making various beds, - an "open bed", a "child's bed", an "ether bed", a "comfort bed", "Buck's extension bed", an "emergency bed" and an "air and water bed". While nurses themselves were not responsible for laundering bedding, they
did have to soak any blood-stained linens before sending them down to the laundry.\textsuperscript{85}

The discharge of an infectious case, as opposed to a clean one, required a more elaborate procedure. Newspapers, a mattress cover, a pillow cover, a linen hamper, a nurses' gown and a dish containing brown soap, a brush, skewer, a duster, three taps and safety pins were accumulated, and the words "to be fumigated" were written in red ink on the labels. The nurse put on her gown, stripped the bed and put the linen in the hamper being careful not to contaminate the outside of the bag. She washed the foot of the bed so as to create a clean surface to work on, laid the mattress on the clean surface and rolled the mattress down, wrapped it in the cover and pinned it together with the safety pins, pinning the label on it. The Mackintosh was washed in lysol "as usual", the pillows and blankets were wrapped in the remaining cover and labelled, and the bed table and chair were scrubbed. The nurse then went to the sink, turned on the tap with a piece of paper, not allowing the gown to touch the sink, undid the gown and washed, took off the gown placed it in a hamper and washed, and tied up the hamper bag, labelled it and washed again.\textsuperscript{86}

Once beds and bedside were once again aseptic, a new patient was admitted and remained in their assigned area for most of their hospital stay. During that time nurses provided personal services assisting patients with ablutions and maintaining the cleanliness of
bed and patient alike. Such services constituted "bedside nursing", the area of nursing work in which caring and curing were integrated most thoroughly. For instance, nurses assisted not only patients with morning and evening toilets and with baths but in addition took responsibility for specific cleaning care of external genitals following a urino-genital operation to prevent post-procedural infections. Nurses also learned the time-consuming but therapeutically important method for changing a bed with a patient still in it. A carefully made bed promoted both the uniformity of ward presentation and prevented patients from acquiring bedsores. Allowing a patient to develop bedsores was a cardinal sin in nursing practice. Given the length of time some patients spent at the hospital, and the length of time patients stayed in bed following hospital procedures, keeping a patient comfortable was not always easy. Early in their training students learned that "wrinkled bed linen," crumbs, lack of proper care and cleanliness, [and] continued pressure" were "direct causes" of the "form of ulcer due to pressure" termed bed sores. "Indirect causes" such as "old age, extreme emaciation, continued high temperature and long continued illness" could also promote the formation of the sores, but whether indirectly or directly caused by nursing practice "prevention" was the surest treatment. A carefully made bed and an evening massage went a long way towards preventing bedsores and promoting a good night's sleep.
Instructions for some procedures stressed gentility and decorum more than therapy. During a bath, nurses were to help a female patient to the bathroom, and ensure the patient did not get chilled. Nurses were informed that "you are responsible for your patients cleanliness, so if patient baths herself see that she is clean noting nails, feet etc." When a female patient was getting into the tub, the nurse was to give her physical support, so the patient could not slip or fall, but the nurse was not to emphasize the patient's dependency; "If she is unable to help herself and does not do it, give some excuse and help her." Patient sensitivities were also considered during meal times. When feeding patients nurses learned that "too full a spoon or one that drips is inexcusable." Some instructions seemed difficult for even a veteran of international affairs to follow. For example, nurses should "never argue with a patient concerning her meals, be diplomatic rather than use force" but at the same time were to be "very strict and give only food that is ordered by doctor." On the one hand the nurse was told "do not discuss food with patient," but then was also instructed to "try and find out patient's likes and dislikes" and to "encourage patient to masticate food well." The degree to which students could negotiate these somewhat contradictory directives depended, in part, on where in the hospital they were working. Retired nurses insisted that treatment did not differ between private and public wards, that all patients received the same care. However it seems clear that 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 patient/nurse ratio was substantially reduced.\textsuperscript{95} As one WGH House Committee stressed, "the service on the private wards would be generally reflected in the patronage of the Hospital."\textsuperscript{96} Even if the content of nursing care did not differ between private and public wards the conditions under which care was dispensed certainly did.

Bedside nursing for infectious patients demanded the same level of personal service, combined with even stricter technique. Throughout most of the 1920s and 1930s patients with infectious diseases such as small pox, diphtheria, measles, and whooping cough were housed in the Municipal Hospitals. There, senior nurses from more than twelve schools of nursing in Manitoba, Saskatchewan, Alberta, and Ontario spent from six weeks to three months learning aseptic care for infectious disease patients.\textsuperscript{97} Students received lectures on the different diseases, and attended clinics at which infectious cases were examined, but the majority of service involved bedside care until the disease ran its course, or the patient died. Myrtle Crawford's infectious diseases training left her with clear recollections of the distinctions between "clean" and "dirty" that defined the internal geography of the Municipal Hospitals.

You had clean areas and dirty areas and the thing that struck us was that the garbage cans were clean, not the inside of them, but the lid, that was clean, you could open the garbage can and close it and you were still clean.
All therapeutic or domestic contact with infectious patients occurred with the nurse gowned, so that preventing disease transmission within the institution depended on putting on and taking off their gowns so as not to contaminate themselves in the process. The method of "walking into and walking out of" the gown was central to infectious disease control. A separate gown was used for each patient, hung, when not in use, on a peg in the isolated patient's room, with the clean side inside. As Crawford explained:

...[when you enter the patient's room] you [were] clean and you just put your hands into the clean area [of the gown] and spread it out and wiggled yourself into the gown and so then you had the clean side next to you and the dirty side out ...[the dirty side] that was not contaminating the patient because it was dirty from the patient [already].

Technique, however, could not contain every micro-organism. For instance Crawford contracted mumps while nursing a mumps victim at the "George". As she recalled "I'm short and in trying to lift [the woman] I was very close to her and she coughed right in my face". The young apprentice landed in the hospital for two weeks, during which time her supervisor asked if Crawford would consent to being used as part of a teaching clinic. Crawford agreed, and shortly thereafter the supervisor brought a group of student nurses "to see this nurse who had gotten mumps." When asked "did you wash your face with soap and water immediately afterwards," Crawford responded that it had not occurred to her, whereupon the supervisor
seized the didactic moment and pronounced "so you see it's your own fault you got these mumps." As the 1920s and 1930s progressed, the medical world was increasingly sensitized to the threat of nurses contracting diseases from patients, particularly in the general medical and surgical wards wherein patients might be admitted for a specific non-communicable affliction, but also carry an undiagnosed communicable disease.

At some point in their apprenticeship the personal care of bedside nursing was extended to a dead rather than live body. Paradoxically, it was the "care of the dead" which integrated all the administrative, therapeutic, and proprietary elements of nursing technique. Immediately after a patient ceased to breath the nurse was obliged to confirm her unofficial diagnosis and "notify [the] intern on [the] service," unless he was present in which case he notified the attending physician. Once the physician had pronounced the patient dead, and family members had left the bedside, having been "treated with kindness and courtesy," the nurse then contacted the admitting office to arrange for removal of the body. The nurse then sent out death slips to the enquiry office or, if at night, the telephone operator, the adding office and the training school office. She then began to prepare the body, assembling equipment at the bedside "as when giving bath." The attendant straightened the body, elevated its shoulders and the head on the pillow to prevent discolouration, and closed the deceased's eyes placing wet plagets on them. Jewelry was removed before rigour mortis set in, unless
the family had requested the wedding ring remain, in which case the ring was secured to the finger by tying a piece of bandage to the ring and then tying the other end around the wrist. Rings and other valuables of the patient were listed on the "value card". Any marks on the body from dressings or treatments were removed with ether, and wounds were redressed with "neat small dressings". The face was washed, false teeth inserted, hair combed and nostrils packed, as was the mouth, and then the jaw was held closed by tying a bandage around the head. The dead body was then ready to be bathed, "as [if] the patient were living." Then the vagina and rectum were packed, the lower limbs were tied at ankles and knees, eyes and lips were lubricated, and the arms, crossed on the chest, were held in place with gauze. If the patient had died from an infectious disease, Lysol was used to wash the body, and forceps used to pack the orifices. As part of the final toilet, the nurse then arranged the patient's hair, combing and braiding it or "if in a home do the hair in the usual way." A tag stating the full name, ward, date and cause of death, date of admission was attached to the bandage at the wrist and at neck.

Once this process was completed, a sheet was carefully rolled around the body, and secured with a safety pin, and a third tape pinned to the sheet. At that point the orderly was notified to remove the body, and it was lifted on the stretcher "gently and reverently". When the hall was cleared of any living patients, the dead body was removed from the ward with "dignity and respect". The
administrative duties of the nurse then continued. The patient's chart was completed with details of the time and cause of death, valuables and value card were sent to the cashier, the list of clothes and any other belongings were sent to the admitting office together with a bundle of any possessions. The packing and washing of male bodies was performed by an orderly, and then inspected by the charge nurse. Even in death nurses were responsible for ensuring the dignity of the patient, guaranteeing the bureaucratic efficacy of the hospital, maintaining aseptic conditions on the ward, deferring to the diagnosis of the doctor, and comforting the survivors. When medical curing failed, nursing caring continued.

In order to learn and perform the range of responsibilities assigned nursing staff, a strict schedule guided students through their days and weeks on the wards. During the first three months of their apprenticeship, probationers were instructed in basic theory and techniques both in the classroom and in practical clinics. If accepted into the program, the newly capped juniors joined the intermediates and seniors in the daily routine of institutional life. For most, the day began at 6:00 a.m. when the night watchman's ringing of a loud bell signalled the beginning of a new day, much to the dismay of tired student nurses. Violet McMillan laughed as she remembered "that darned bell, I felt like throwing it out the window." Nurses scrambled to get groomed and dressed, and to make their beds before assembling at 6:30 in the residence foyer for morning prayers. Following the scripture and hymn, nursing
supervisors would occasionally inspect nurses' uniforms, and tardy nurses became adept at completing their grooming in the back row before prayers were completed. No morning exercise took too long, for nurses had to eat breakfast and be on their respective wards or specialties ready to work at 7:00 a.m. Some nurses went off to the Outpatient Department or the Operating Room, while others made their way to the medical, surgical, maternity, or private wards.

At their assignment, nurses assembled again to hear the charge nurse's night report communicating to day staff pertinent patient information, after which each nurse was assigned specific duties for that day. Junior nurses were responsible for four to six patients, and for each patient the nurse completed their morning toilet, fed them breakfast, made their bed, and cleaned the area around the bed, while more experienced nurses performed the various treatments required. All tasks had to be completed before attending doctors arrived to examine and treat their patients. During that time, the senior charge nurse accompanied physicians and surgeons on their rounds of the ward, while other staff performed other cleaning and administrative duties. Soon after doctors left, lunch was served, and nurses ensured their patients were fed, and cleaned ready for visiting hours in the afternoon. Sometime between 10:00 a.m. and 4:00 p.m. each student left the ward for three or four hours to attend classes, but then returned to patients who needed treatments repeated, dinner served, their evening toilets and their backs
rubbed.\textsuperscript{106} No staff members left the ward until all work, including cleaning the service room, was completed, which occasionally kept nurses on duty until 8 or 9:00 p.m. Nurses returned to the residence to eat their own dinner, study, and usually pile into a friend's room to talk over the day's events. Once a week students could go out in the evening, but had to be back in the residence by 10:00 p.m., and lights were out shortly after. As well, nurses were granted one night per month "late leave" which extended nurses' curfew. Meanwhile, other nurses had just begun to work, starting evening duty at 7:00 p.m. or the night shift at 11:00 p.m. In the evening, nurses ensured that patients went to sleep, occasionally with the aid of sleeping pills but more often with the help of a massage or a cup of hot milk.\textsuperscript{107} During the night the lone nurse on duty monitored patients, performed prescribed treatments, prepared equipment and supplies needed the next day, and remained ready for any emergency admissions or procedures.\textsuperscript{108}

The schedule and routine which directed daily life for apprentices in Winnipeg's hospitals ensured that the unsupervised and inexperienced student staff would perform correctly their medical therapies, patient services, domestic tasks and administrative duties and at the same time maintain the decorum and gentility of relations within the institution. While rules guiding the behaviour of nurses on and off duty did not entirely cloister the young women enrolled in the various schools, feminine respectability was demanded. At the same time the military
discipline of uniform inspection and standing at attention drew on the military model of ensuring obedience and discipline. But a third organizational structure also informed the structure and content of nursing work, and that was the obvious administrative borrowing from the industrial model of rationalized production. Even the imagery of the 25 to 40-bed wards, with each bed equidistant apart, each patient’s table and chair placed right next to their beds, each patient covered in identical bedding, with all blankets tucked tight at the end and sides, called up mental images of assembly-lines. Not surprisingly hospital vocabulary matched the interior design in its allusions to industrial production. In 1921 WGH Superintendent Stephens included in his annual report "An analysis of the work of the year, that is, what might be called 'the production sheet' of the Hospital." 

The necessity for hospital administrators to increase "production" per nurse intensified throughout the 1920s and 1930s as institutional funding dwindled and length of patient stay decreased. Unlike the captains of industry, however, these patriarchs of medical institutions did not have to reconceptualize skills into component tasks. That job had been done for them by the very nature of modern medical techniques. Superintendents built upon these routines by reorganizing records, supplies and the placement of patients. Initially this latter approach involved shifting care of chronic cases back into the community, and focusing hospital work on acute, and as often as possible curable,
cases. Even the "boys" on the military flats whose tragic treatment from shell shock and gas of the "Great War" had earned them a privileged status in Canadian general hospitals were slowly moved out to other facilities so as to make room for cases more pressing and more likely to become "success stories" of the medicine of the day.112 Once this process was completed further increases in hospital production could only be achieved by intensifying the pace of work for student and staff nurses alike. Borrowing from the time management strategies popular in industrial production, in 1924 Stephens investigated the care of chronic patients at WGH and concluded:

A study of the nursing service required shows that three to eight hours daily may be occupied in looking after such a case. Care is essential, otherwise they would not be in hospital, but this care, frequently does not call for skilled nursing, but merely personal attention, which can be received elsewhere at a much lower cost if suitable accommodation were available.113

Stephen's ability to increase the efficiency of his institution rested upon his success in eliminating patients who consumed precious nursing time with personal "non-medical" needs. Convalescent patients were removed from WGH wards, and only severely acute patients were accepted.114

Under pressure for ward space, the routines of nursing procedure served the needs of medicine, of administration, and of
patient, but also served nurses. The procedures and ritual which defined nursing work also served to defend it, as nurses used overt and covert forms to resist unreasonable demands of their work time. Nurses often resisted and defended their skills by using the technique to determine the content and pace of their work. Workplace resistance by nurses took particular forms, for unlike industrial workers the product on which nurses directed their labour was not inanimate. A patient might be unconscious, but even then family and friends ensured that a patient's interests were protected at least to some degree, and the patients remained an active force influencing relations at work. The classic dichotomy between manager and worker upon which much labour history is based is an insufficient model through which to understand the complex relations among doctors, administrator, patients and nurses. Defence of the nurses' own definition of good nursing required overt and covert forms of resistance aimed sometimes against patients, other times against doctors and still other times against supervisors. And, conflict with one often depended upon support from and alliance with the other.

Occasionally, nurses directly confronted their superiors, an act which inevitably brought students before the nursing superintendent. Olive Irwin "had to stand on the pink mat" before Superintendent Powell when, after a particularly long night of duty Irwin took umbrage to a supervisor's criticism regarding Irwin's technique. In that instance, "saucing a head nurse" only resulted in Irwin's
transfer to another ward, primarily because the student's apprenticeship was almost finished.\textsuperscript{117} Such was not always the case. Many other students were either sent home or quit because of poor technique and workplace conflicts.\textsuperscript{118} Offending students could appeal their cases to the Training School Committee, and then on to the House Committee, but these appeals produced little more than administrative discussions of the "obligation of Hospital to the parents of the student nurses whose work was not satisfactory." In most cases the nursing superintendent was supported in her efforts to "improve the efficiency of the School, character of the nursing and the behaviour of the student nurses."\textsuperscript{119}

Conflicts arose rarely with the medical staff, and most often involved graduate rather than student nurses. Most undergraduates like Grace Parker had limited interaction with doctors. Until receiving a senior posting, such as charge nurse or scrub nurse, communication from doctors to students came through experienced nurses. Upon graduation nurses became more assertive. Parker for instance was criticized for technique by a surgeon she assisted during employment in the WGH operating room. She considered his comments unfounded as she was following the technique as instructed, and to make matters worse he had criticized her in front of a visiting physician. After the operation, she "tackled him" and "really bawled him out....I felt he was being very unfair to me and I wasn't going to take it." Parker's bravado stemmed from her self-perception that "I had graduated by that time, I was a real RN."\textsuperscript{120} In
other instances, if nurses were unsure of a medical directive they could communicate through their nursing superintendent, but those senior administrators tried to reserve confrontations with medical staff for larger issues. Myrtle Crawford's efforts to confirm a medical order through her superintendent met with the response "You've got the order, give it." Most nurses, student or staff, kept their opinions of medical practice to themselves. Mabel Lytle supported herself until retirement with private duty work, and while she sometimes did not agree with the doctor attending her cases, she did not voice her opinions.

Given the overriding authority of the medical profession, most nurses employed much more covert forms of resistance. One of the Manitobans who made their way to the West coast to find work recalled one strategy used to negotiate with difficult doctors. Since only a fine line differentiated student and graduate nurses in the hospital, doctors could distinguish one from the other by their stocking colour, students wore blue, staff wore white.

We had an incident in the Operating Room when we got up there and were working. One surgeon was very fussy and always wanted a Graduate to scrub for him. At night we didn't have that many Graduates on, you see, they'd be students on, so our Supervisor always kept white stockings up there and when any of us had to scrub for this man we took off our black stockings and shoes and she gave us white stockings, because he always looked down to see. If he saw white stockings that was fine he'd go and scrub.
The legal authority of the medical profession made nurses unwilling to challenge doctors. Within the hospital, as with the broader socio-legal framework, medical authority was supported by professional legislation which empowered the medical profession to define new medical functions and to assign specific tasks to subordinate workers. But nurses were motivated to maintain collegial relations with doctors for other, more subtle, reasons. Nurses often acquired work through medical referrals, and once on the job, the medical practitioner was an important ally. This was particularly true in private duty which placed nurses alone in patient homes for long periods of time. Medical endorsement of nurses' work was necessary for the health of the patient, and perhaps for the legal protection of the nurse. For example, in June 1937, Brandon General Hospital graduate Wilma Mitchell was working in Gainsboro Saskatchewan providing domestic nursing care for a male heart patient. Concerned about her patient, and about the course of medical treatment prescribed, nurse Mitchell wrote to a medical practitioner she knew from her hospital training, Brandon doctor W.A. Biglow. Dr. Biglow replied to Mitchell, thanking her for her "very informative and intelligent letter re [the patient]" and assuring her that her use of strychnine was appropriate. After detailing the strength and frequency with which the patient should be administered "some simple Strych. grain, not the hype tablets", Biglow declared:
the treatment of these heart cases is purely clinical. We must depend on the nurse—her judgement and observation, etc. and if you find that the hypo of strych regulates the pulse, then give it to him.\textsuperscript{125}

Nurse Mitchell maintained the correspondence, and was still with her Gainsboro patient when Biglow's second letter arrived, dated June 23, 1937. Biglow refined his prescription, and again encouraged Mitchell to use her judgement regarding the course of treatment.

You are doing the right thing for [the patient]. The only thing you have to contend with is his stomach, and its relation to his food and medicine. If you cannot give him a dose of medicine in the morning give him 1/200th of Nitro. Glyc., 1.30th (or 1.40th) Strych, and 1.50th digitalin, in place of the medicine, as one does not want to give hypos of it it can be taken by the moth as digitalin has a tendency to make the arm sore. Codein for sleeplessness.\textsuperscript{126}

This correspondence reveals two critical features of doctor-nurse interaction. For nurses such as Mitchell, working in relatively isolated conditions,\textsuperscript{127} medical assistance from practitioners such as Biglow assured the nurse that her patient was receiving an appropriate therapeutic regimen. However, the fact that Mitchell kept the letters points to the potentially precarious legal position of nurses, and the protection that such written evidence offered should her treatment be questioned.
The most forceful forms of overt conflict occurred between nurses and uncooperative or unhappy patients. For example, Ingibjorg Cross once received instructions to treat a patient with an infection by applying foment to an infected area every 15 minutes during the night. Cross did so, each time being careful not to wake the patient. The next day the doctor mentioned the foment to the patient, who replied that he had received no such treatment. In front of all the other patients, the doctor promptly questioned Cross regarding her alleged negligence. Her defence that she had followed the prescribed treatment was corroborated by the other patients who each told the doctors that every time they had witnessed Cross dutifully applying her foment. Somewhat annoyed, the doctor instructed Cross to continue her treatment, but to wake the patient for every procedure. The tactic worked, and Cross recalled that the exhausted recipient of her nocturnal care "begged me to quit...he had his lesson."\(^{128}\)

Some conflicts with patients had more violent resolutions. Myrtle Crawford's father had never been pleased with her decision to enter nursing, so she did not tell him about her experiences of being physically attacked by patients. During one night shift, a deluded patient grabbed her and tried to pull her into bed. She was saved by an orderly, who insisted that she report the incident. Crawford suspected he regretted his advice when the night superintendent "rewarded him' by telling him that [Crawford] was not to go into that ward again and he had to look after it entirely." On another
occasion, Crawford was patrolling a dimly-lit ward during her night shift.

I was just going down the hall and I was carrying my flashlight when he came darting out of his room and grabbed me by the throat and he had me down on my knees by my throat and I couldn't call out or anything, and the orderly happened to come down the hall at that particular time and put him back in his room.129

Crawford later determined that the WWI veteran had mistaken her flashlight for a gun.

The survivors of such incidents usually considered them humourous in retrospect, and much nursing mythology rests on the bizarre events often occurring on night duty. As an Intermediate, one nurse drew the 6-week rotation as night-float twice in a row. One night, she was assigned to a patient who was recovering from an anaesthetic. He had been in a bed in the hall before the operation, and following it was returned to the ward still anesthetized. The night float was carrying out her responsibility of "watching" him until he safely came out of the anaesthetic. As he did, the groggy patient asked the nurse where he was. Trying not to disturb the other patients on the ward, the nurse whispered "you're on the ward." The patient sat straight up, looked down the uniform row of sleeping patients on the moonlit ward and exclaimed "In the Morgue?" and then proceeded to try to escape. The nurse leapt up, held him down in his bed, and with the help of the night supervisor managed to.
convince the patient that he had not been incorrectly proclaimed dead. Such shared plight and the knowledge that emergency situations would bring rapid assistance from graduate staff bred among apprentices great loyalty to their nursing superiors. Night supervisor at the Winnipeg General Hospital Margaret McGillvray was a favourite of WGH students because of her calm in the face of such crises. Experiences such as Mary Shepherd's must have pushed women like McGillvray to her limits. Shepherd had been assigned night observation on the "noisy" ward when a patient escaped out the window. Shepherd rushed to the door and rushed out after him, but halfway across the street realized she had left her 24 other patients alone and gave up pursuit. Fortunately the driver of a passing car caught and returned the errant patient, so while the orderlies, some nurses and Miss McGillvray united to hold him down, Shepherd prepared the strong sedatives as ordered by the doctor.

He was fighting full force, it was just terrible, and he was swearing at us and threatening that everyone involved was going to be murdered...he was lying perfectly still and Miss McGillvray was helping to hold him and just as I went to jab him with the needle he jumped and the needle went into Miss McGillvray's thumb.

The "excitable" McGillvray asked "did you lose any, did you lose any," and getting a negative response, instructed Shepherd to "put it into the patient." In spite of Shepherd's assurance to McGillvray that
none of the sedative had been lost it was not until several hours later when McGillvray was "still going strong" that Shepherd was sure that her assurances had been correct.132

In other situations students were not as pleased to see McGillvray. Assigned to night duty on "D Flat" the soldier's ward, Myrtle Crawford came on duty to take over from a classmate on evening duty only to find chaos ruling and her classmate "walking up and down the corridor wringing her hands [saying] 'what'll I do, what'll I do.'"133 Without waiting to find out what had happened Crawford " barged into the men's washroom" broke up the fight occurring there, and ordered the men back to bed. Having restored order, the night nurse discovered that the men had convinced the evening nurse to let them have a birthday party for a patient. As Crawford recalled:

Their party was booze, and they were all high so I told them to get into bed and to pull the bed cloths up over their heads because the night supervisor was coming around and I didn't want to see one person out of his bed. And there wasn't. By the time she came everybody was quiet in bed, and of course the whole ward reeked of liquor and you can't tell me that the night supervisor didn't know what was going on.134

Fortunately, the assistant supervisor, not McGillvray herself, had come to check on D Flat, and Crawford concluded that McGillvray, a nursing sister in WWI, had purposely sent her assistant to the scene: "you can't be a nurse overseas and not know what went on that night."
Unlike her assistant, who could keep her suspicions quiet, if McGillvary "knew about it she would have to take action."\textsuperscript{135} Whether McGillvary's absence was intentional or not, Crawford's belief that the veteran supervisor purposely avoided the potentially disastrous scene reflected the admiration and affection felt for role models like McGillvary. Another WGH graduate, Beryl Seeman, recalled that, every November 11, McGillvary, a WWI veteran, "used to get into her army regalia and sell poppies, she was quite a character and we were very fond of her."\textsuperscript{136} Graduates of other years echoed Seeman's sentiments because the discipline and confidence women like McGillvary offered the younger generation mediated some of the harsher features of hospital discipline.

While not all relations between supervisors and students provoked such warm memories, students such as Mary Shepherd modelled her own behaviour as supervisor after positive examples like McGillvary. As nursing administrator at the Municipal Hospitals, Shepherd welcomed her students into her suite in the evenings, where all would enjoy their evening snack and listen to Shepherd's radio.\textsuperscript{137} The pride with which Shepherd recounted her "good relations" with students reflected the importance many nurses continued to place on inter-generational relations between veteran nurse and young apprentice.

For student nurses confronting for the first time the disciplined routines of life and work in the hospital, the role model
senior nurses provided united them around the identity as skilled working women and helped them accept the content of nursing work. "It didn't seem like a very important thing but afterwards when we were on the wards you could see that a room looked much better with the beds all uniformly made, so there really was a purpose...." Nurses soon came to realize that the precision expected of students stood them in good stead once they were expected to assume full responsibility for patient care. Myrtle Crawford concluded "if you learned how to do it perfectly you wouldn't go too far off if you got careless."

Not all supervisors managed to engender in their disciples the respect and affection awarded women like McGillvray and Shepherd. Distinctions between supervisors and staff made clear by the strict discipline meted out by the Training School Office were accentuated in years when large enrollments distanced even further graduate nurses from apprentices. However, the complex relations among nurses, doctors, patients and administrators precluded the emergence of permanent oppositional relations between any two groups, and at the same time the structure and content of nursing work created a common bond between nurses and their administrators not possible between nurses and doctors or nurses and patients. The content of nursing practice, based on specific aseptic and administrative techniques, provided nurses with a clear self-definition as skilled workers as well as a source of resistance against unreasonable workplace demands. Their mobility through the
nursing hierarchy ensured that most distinctions among nurses were only temporary -- distinctions between nurses and doctors and nurses and patients on the other hand were not.

If superintendents of nurses retained superior authority over all nurses in the hospital, whether student, staff or special duty, they also served as important role models for the young women seeking social status and financial independence. Commanding status and authority in the hospital, and high profiles in their communities, superintendents represented to single women the reality of maintaining financial independence and represented to married women the possibility of returning to active practice should marital finances fail. Many nurses married and never again supported themselves or their families through paid nursing work, but the knowledge that they could regain financial independence provided them with a power in society not possessed by many women. That power was the ability to claim skilled status and wages in a patriarchal society deeming women's work as unskilled and worth-less. Nurses' identity as skilled attendants served to defend them in the workplace and also to define them in society. Nurses were nurses for life, even if they only practiced their trade for a short time.

The first conclusion to be drawn from this examination of nursing practice is that since at least 1920 nursing work must be conceptualized as scientific, in that it was based upon the
theoretical understanding and practical application of the germ theory. Some nursing historians have been hesitant to claim scientific status for nurses' work during these years. Barbara Keddy and others posed the question was nursing work "scientific or 'womanly ministering'?" Their conclusion, that "because of the limited amount of medical knowledge of the 1920s and 1930s... nursing's "hand's-on technique" would have been considered to have been appropriately scientific for the era, " suggests that these authors have conflated scientific theories, upon which modern medical practice rests, with the technological interventions which have characterized post-World War II health care. While hospital nursing staffs were responsible for an array of administrative, therapeutic and domestic tasks, the maintenance of aseptic conditions through nursing technique was central to each.

Secondly, in two decades of limited therapeutic advances by medicine, this effective nursing practice was central to the emergence of institutions as the preferred locus of treatment. It was based on the adherence of nurses and doctors alike to aseptic techniques. The preoccupation within nursing training with maintaining a sterile field, and the conviction amongst nurses that such a standard was consistently maintained speaks to the success of nursing's preventive techniques as a scientific practice. Given the infrequency of medical attendance in the institution the ability of hospitals to provide medical interventions without creating hospital-based complications was dependent upon nursing
practice. Clearly the role of nursing technique in the growth of hospital success and public popularity was key.

A third conclusion returns to the question of deskilling. Central to Braverman's definition of deskilling is the separation of conception from execution. With the professionalization of medicine in the late nineteenth century, doctors retained the right to conceptualize medicine, to diagnose and prescribe. Nursing emerged in its modern form to provide "the physician's hand", that is to execute medical directives. However, since that time, the absolute number of skilled tasks performed by nursing has actually increased. This examination of the content of nursing work establishes the many difficult procedures for which nurses were responsible. Indeed, as Bellaby and Oribabor have noted, "to all appearances nurses have become more skilled over the [past] 100 years." Such scholars correctly maintain, however, that the increase in the absolute number of skills does not disprove the deskilling thesis. They emphasize that "specialization among nurses has followed specialization in medicine, not proceeded independently of it" and that routinized techniques ensures doctors' control over patient care. However, the preoccupation with medical and technical rationalization of skills -- the shift from the craft of caring to the science of curing -- obscures the ways in which nurses themselves defined skill on different terms. For them skilled nursing demanded the mastery of an elaborate set of techniques which embraced both caring and curing. The focus on the control of
scientific skills does not capture nurses' efforts to reconceptualize caring. Their inability to claim social and economic value for their skill speaks to the historic difficulty women have experienced demanding recognition for their skills.148

Thus, while doctors, hospital administrators and nursing educators each had their own agenda for enforcing technique -- be it industrial time management, professional control over a subservient workforce, or commitment to professional status through science -- nurses themselves accepted and endorsed their technique. Effective technique protected nurses' own health, while at the same time legitimized their claims as skilled workers. For women working in a sex-segregated economy which by definition assigned women's work as unskilled and low status, apprenticeship and certification as a nurse differentiated these practitioners from womanly service. Thus should marital prospects fail, never materialize, or be rejected,149 the skilled status and wages nurses could command promised personal and financial survival, and perhaps independence.

Recognizing the link between nurses' workplace experiences and the patriarchal limitations they faced outside of the workplace raises an important question regarding the concept of work culture. At one level, the experiences and recollections of nurses at the Winnipeg General Hospital suggests that work culture is indeed an appropriate conceptual model for characterizing nursing work in the
1920s and 1930s. For nurses, scientific medicine was a method of both caring and curing, and as such aided them in "[staking] out a relatively autonomous sphere" on the job.\textsuperscript{150} Certainly the dynamic at the workplace was complicated, as Susan Porter Benson has reminded us, by the presence of the client, the patient. As well, the interaction between second and third generation nurses, between student nurses and their graduate nurse role models, ensured that nurses' own definition of good nursing and good technique was transmitted, and reinforced. And yet, nurses' self-perception extended out beyond the ward or the home into the public sphere and throughout the practitioners' lives. The concept of work culture fails to account for the power and particularity of nurses' occupational identity, an identity which nurses took with them onto the streets, and, as Chapter 6 documents, into the political realm, but an identity which was being challenged from within during the interwar years by the economic difficulties facing working nurses.

In many ways the uniform nurses donned during each working day revealed the contradictions of nurses' claims to skilled status. On the one hand, nurses' uniforms represented the military discipline and subordinate status which defined nurses' training \textit{vis a vis} their superiors. Equally important however was the occupational pride nurses uniforms signified and reinforced. The occupational identity which developed out of the structure and content of nurses' work was a source of resistance in the workplace and a source of identity in society and throughout their lives. The disproportionate emphasis
placed on the uniform in nursing memorabilia suggests its importance in the manifestation of nurses' identity. Student nurses were forbidden from wearing their uniform except when on duty. At the Winnipeg General Hospital, as elsewhere, nurses were expected to wear their uniforms at all times while on duty, but were never to wear their uniform after hours. Even the CNA became concerned with their occupational symbol when in 1936 the national body struck a committee to investigate "the Use of the Figure of a Nurse in Commercial Advertising". Nurses across Canada agreed on the power of nurses' public presentation. In the words of veteran superintendent Kathleen Ellis "remember your dignity, it is your appearance to your fellow man that causes them to respect you."152

The story told by Mary Shepherd of her experiences working as a student at the Margaret Scott Mission provides a humorous insight into the symbolic meaning nurses' vested in their uniform. During her rotation at the Margaret Scott Mission, Mary Shepherd was called one night to assist a local doctor deliver twins at a North-end home.

...the doctor asked me if he'd like him to wait for me and I said 'no we weren't too far from Main Street', so I proceeded about 3:30 in the morning all by myself down there.

As Shepherd started down Euclid Avenue, towards Main Street and its streetcar, a man appeared on the sidewalk beside her. All the way to Main Street he walked beside her, saying unrepeatable things to her all the while. Shepherd recalled: "I was on the other side
behind the CPR Station and it felt like about a hundred miles to Main Street." She managed to make it safely to the street car, flagged down a policeman to escort her up George Street to the Mission, and upon her arrival at 99 George Street "just fell in the door and howled my head off." While Shepherd did not report the incident to the Mission, and "the General didn't find out about it until our Yearbook came out," her story spread quickly amongst the students, and remains a standard in WGH nursing mythology, reminding retired nurses from the interwar era of their pioneer status. While the story served as an important reminder of the many adventures encountered, and of the fact that nurses were breaking new ground as independent women, Shepherd's response to her harasser evoked the symbolic strength of identity nurses invested in their uniform. As the man talked to her on what seemed like her endless journey to Main Street, Shepherd simply replied, "No thank you" and explained "...I wasn't getting into any fights because I was a nervous wreck." However, as she boarded the streetcar and escaped her harasser Shepherd flung a comment back to offending man -- what she still considers a "noble" response: "If you don't respect me you might have respected the uniform."153 Neither sexual harassment, nor criticism from patients or doctors or administrators, nor dark of night could shake the occupational pride of nurses' identity.
Notes


2 While curriculum guides and texts provide useful information as to the prescribed content of nursing training they do not describe what was actually taught. See for example, Canadian Nurses Association, A Proposed Curriculum for Schools of Nursing in Canada (Montreal: Canadian Nurses Association, 1936).

3 Webster's Dictionary defines science as "accumulated and accepted knowledge that has been systematized and formulated with reference to the laws of general truths or the operation of general laws", and emphasizes that this knowledge is "obtained and tested through the use of the scientific method". Webster's Dictionary (Springfield, Mass: Merriam-Webster, Inc., 1986): p. 2032.

4 See S.E.D. Shortt "'Before the Age of Miracles' The Rise, Fall and Rebirth of General Practice in Canada, 1890-1940" in C. Roland, ed., History, Disease and Medicine: Essays in Canadian History (Waterloo: Hannah Society for the History of Medicine, 1986), p. 139. He points out that, while the etiology of prevalent diseases had been established, the only effective cures were Salvarson for syphilis and the diphtheria antitoxin. For most other diseases medical treatment remained "supportive".


8 See John Lawrence Runnalls, A Century with the St. Catharines General Hospital (St. Catharine's Ontario: St. Catharines General Hospital, 1974) for a description of some of Mack's more dramatic contributions to Upper Canadian society, including Runnalls' claim that "Like every man of original views, Dr. Mack had to face the storm which the ignorant, the envious and the disinterested raise against those who seek to serve mankind in a better way." p. 4.


10 Provincial Board of Health of Manitoba, "Practical Hints for Checking the Spread of Infectious Diseases and Other General Information upon matters of Sanitary Importance" (Winnipeg: Provincial Board of Health, n.d.) (Kathryn McPherson Collection).

11 Ibid.

12 Provincial Board of Health of Manitoba, "Practical Hints for Checking the Spread of Infectious Diseases." The sample vaccination forms at the end of the publication list the date of vaccination as 189_, indicating the decade in which the pamphlet was created.
13 For example, Alan Artibise argues that public health programs were supported by middle class residents fearful of infections spreading from poor neighbourhoods, Alan Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914* (Montreal: McGillQueen's University Press, 1975), pp. 227-229.

14 "Senior Lecture Notes" December 16, 1910, (WGHAA Archives). The student was referring to German scientist Robert Koch.


16 "Senior Lecture Notes," January 6, 1911 and January 19, 1911.

17 Ibid.

18 Winnipeg Municipal Hospitals, "Manual of Technique for the care of Communicable Diseases, 1928" (Winnipeg: Mary Shephard Collection).

19 Ibid.

20 Ibid.


22 Ibid.


24 Harvey Agnew asserted that "few men in the administrative field in this country have made such a massive contribution as did George Stephens..." Stephens was elected president of the American Hospital Association for 1932-1933, was named as fellow of the American
College of Hospital Administrators in 1933, and assumed presidency of the Canadian Hospital Council in 1939, a position he held until 1946. The American Hospital Association awarded him the "much-coveted Award of Merit" in 1946, and in 1949 the Canadian Hospital Association established an award in Stephens' honour. Harvey Agnew, Canadian Hospitals, 1920 to 1970: A Dramatic Half Century (Toronto: University of Toronto Press, 1974), pp. 72-73.


26 For example, at the Vancouver General Hospital a doctor was chastised by the House Committee and Board of Governors because "his language to members of the Nursing Staff before doctors and patients, and his criticism of the administration and Staff before patients is unethical and unprofessional." Nursing supervisors agreed that the doctors "should report any complaints directly to headquarters, if he had any, rather than to abuse the Nurses in front of the patients." VVGH Special Committee, Minutes, 27 September, 1929. VCA Add MSS 320 Series A.

27 Joanne Whittaker argues that "BC nursing leaders, too, did not disturb the sexual division of labour...Like good wives in their homes, nursing superintendents maintained their hospitals in an efficient manner, inculcating pupil-nurses into their occupational role." Joanne Whittaker, "Professionalization and Gender: The Case of the Registered Nurses Association of British Columbia," (Unpublished paper, Fifth BC Studies Conference, November, 1988): p. 36.

28 WGH House Committee, Minutes, October 22, 1928.

29 VGH Board of Directors, Minutes, 10 April, 1916. VCA Add MSS 320, Series A.

30 Helen Smith, interview by author, Tape recording, Winnipeg, Manitoba, 3 August 1988.

31 Jo Mann, interview by author, Tape recording, Abbotsford, B. C., July 22, 1988.
32 Mary Duncan, interview by author, Tape recording, Winnipeg, Manitoba; 22 June 1987


34 Ibid.

35 Mabel Lytle, interview by author, Tape recording, Winnipeg, Manitoba, 30 June 1987.

36 See Chapter 6 for a discussion of Alumnae involvement in such ceremonies.

37 Nurses' Alumnae Annual 1928 pp. 69-73 "Winnipeg General Hospital School of Nursing" pp. 70-72 lists the "practical experience and theoretical instruction" given as tabulated from the year 1924-25.

38 The conceptualization of these six categories emerges from the four nurses' personal handbooks, property of the WGHAA Archives, and of Myrtle Bowman, Winnipeg, Manitoba, as well as from oral interviews and archival source material. I have purposely avoided basing my descriptions of the work on curriculum guides because of their prescriptive nature.


40 Interview participants did not discuss these books until I discovered their existence and began to inquire about them specifically.

41 Myrtle Crawford, Tape recording.

42 The absence of substantial daily or weekly records of nursing staff work is the result of two historical phenomena -- overwork of
nursing supervisors so that detailed records of ward work were not kept, and limited storage space within institutions so that those records which were created were often destroyed years later. Mary Shepherd, superintendent of Winnipeg's Municipal Hospitals, showed me records of her training at the King George Hospital which she had salvaged for personal and sentimental value when ordered to burn the old nursing staff records due to lack of storage space. Daily ward registers were however, kept for earlier years of the hospital when staff size, patient load, and patient turnover made such record keeping feasible for the limited administrative staff.

43 All procedures for patient care on the ward, as compared to patient services in specialties such as the Operating Room and the Infectious Diseases Hospitals, were taught students in their first two years at the hospital. Institutional organization rested on the division of patients into medical, surgical and maternity wards, with special services such as, pediatric, infectious, mental, military and Eyes, Ears, Nose, and Throat (EENT) being established and dissolved according to the shifting hospital mandates. Patients were also housed according to their sex, and according to their public or private status. See Chapters 4 for a discussion of hospital organization in the city. Ethel Johns and Blanche Pfefferkorn, then Director of Studies for the American organization, National League of Nursing Education, co-authored a study of nursing. That 1934 publication was strongly influenced by time-management concepts, and attempted to statistically breakdown nursing work into its component parts. In doing so the many areas of personal care which nurses provided were either ignored or subsumed under broader categories. Since the Johns-Pfefferkorn categories do not capture the detail of nursing life which emerges from interviews and student notebooks I have not used them. Ethel Johns and Blanche Pfefferkorn, An Activity Analysis of Nursing (New York: Committee on the Grading of Nursing Schools, 1934).

44 Samples of lectures notes reveal instructors' initials and occasional comments, as do some of the red books consulted. Violet Erickson, Lecture Notes, (1929-1933) (WGHAA Archives); Myrtle Bowman, Notebook.

45 Violet Erickson, Lecture Notes, p. 99.
While most surgical procedures were performed in the operating rooms, clean or dirty, some continued to occur on the wards.

A Mackintosh was an inflatable rubber sheet which when sterilized served as an aseptic surface and a waterproof covering for any treatments involving liquids, to keep from soaking the mattress etc. for patients to lie upon. Violet Erickson's Notebook described the disinfecting process for Mackintoshes: "Immerse in Lysol solution for twenty minutes (2% solution). Wash, rinse and dry inside and outside. Inflated. Put away."
58 Ruby Bowman, Notebook. See also, Harriet Pentland, Tape recording.

59 Myrtle Bowman, Notebook.

60 Ruby Bowman, Notebook.

61 Myrtle Crawford, Tape recording.


63 Beryl Seeman recalled the war and post-war years when nurses first started giving intramuscular injections, and taking blood pressures. The doctors were not all in support of the redistribution of tasks but could not keep up with all their tasks otherwise. Beryl Seeman, interview by author, Tape recording, Winnipeg, Manitoba, 8 July, 1987.

64 WGH Reports and Accounts, 1919-1943.

65 Violet McMillan, Tape recording.

66 During the 1930s some students were placed with the VON to acquire the home nursing and district nursing experience offered since the 1920s by the Margaret Scott Mission, Vera Chapman, interview by author, Tape recording, Winnipeg, Manitoba, 2 July 1987.

67 Isabel Cameron, interview by author, Tape recording, Winnipeg, Manitoba, 1 July 1987.

68 Ibid.

69 Ibid. Other nurses shared similar experiences. For example, Grace Parker was called to attend a birth during her training at the Margaret Scott Mission, only to arrive and discover the woman did not have a doctor. By the time the interns from WGH arrived the baby was born. Grace Parker, interview by author, Tape recording, Winnipeg, Manitoba, 25 June 1987.
70 Olive Irwin, interview by author, Tape recording, Winnipeg, Manitoba, 3 August 1988.


72 "Senior Lecture Notes," 1910.

73 Research on nurses' working in Nova Scotia during these years revealed the same emphasis on fomentations and poultices. See Barbara Keddy, "Private Nursing Days of the 1920s and 1930s in Canada," *Canadian Woman Studies*, 7, no. 3 : pp. 99-102.

74 Violet McMillan, Tape recording; see also Mary Duncan, interview by author, Tape recording, Winnipeg, Manitoba, 22 June 1987.

75 Erickson, *Notebook*, describes the procedure for preparing a non-sterile fomentations.

76 Beryl Seeman, Tape recording; see also Mary Duncan, Tape recording; Violet McMillan, Tape recording; Vera Chapman Tape recording.

77 Beryl Seeman, Tape recording


79 Ruby Bowman, *Notebook*.

80 B.W. Payton's "Medicinal Leeching: The Golden Age", *Canadian Bulletin of Medical History*, 1, 1 (Summer 1984) maintained that "even respectable 20th century medical texts continued to mention [leeches'] use" and cited a 1949 British nursing text which instructed students "of the correct way for preparing a trolley for leeching," p. 86. Nursing historian Joanne Whittaker informed me that leeches have been resurrected in modern medical practice.

81 Violet Erickson, *Notebook*.

82 Myrtle Bowman, *Notebook*. 
83 Harriet Pentland, interview by author, Tape recording, Winnipeg, Manitoba, 13 June 1986. See also Violet McMillan, Tape recording; Furby Thorolfson, Notebook; Violet Erickson, Notebook.

84 Furby Thorolfson, Notebook. Probationer Furby Thorolfson's 1924 instruction on the method of stripping a bed insisted:

To strip a bed
1. Place table and chair away.
2. Place pillow on chair with closed end towards door.
3. Loosen linen.
4. Fold linen from foot of bed in quarters.
5. Turn mattress.

85 Harriet Pentland, Tape recording.

86 Ruby Bowman, Notebook.

87 A procedure used: "After urination and defication following repair of perinum, scraping and washing out of uterus childbirth and abortion", Violet Erickson, Notebook.

88 Violet McMillan, Tape recording. Violet Erickson, Notebook; Furby Thorolfson, Notebook.

89 Violet McMillan, Tape recording. Retired nurses commented frequently upon the length of time that parturient women stayed in bed following delivery during the interwar years, and agreed that the more recent trend of having new mothers "up and about" soon after childbirth has been a positive one.

90 Ruby Bowman, Notebook.

91 Every graduate nurse interviewed insisted that a massage and a cup of hot milk before bed accomplished what sedatives now do for hospital patients.
92 Violet Erickson, *Notebook*.

93 Ibid.

94 Violet McMillan, Tape recording.

95 In 1926 the WGH House Committee allocated $55 per floor to equip the private wards with flat silver. WGH House Committee, *Minutes*, 4 Jan 1926. Helen Smith recalled a reduced patient/nurse ratio on private wards, and the china cups in which private patients were served their tea, Helen Smith, Tape recording. Myrtle Crawford stated that private patients had a choice of menus, and their food trays were set attractively, with cloth tray covers and cloth napkins, Myrtle Crawford, Tape recording.


97 Mary Shepherd's 1928 record of her first day on staff at the Municipal Hospital lists students from Morden General, St. Joseph's, Children's Winnipeg General, Virden, Neepawa, Weyburn and the Misericordia, as well as the small contingent of undergraduates taking the "short course" in contagious diseases that the Municipal offered. Municipal Hospitals, "Staff Record", August 8; 1928 - August 27, 1928 (Mary Shepherd Collection).

98 All 16 WGH grads interviewed repeated the same precise set of steps for gowning.

99 Myrtle Crawford, Tape recording.

100 Ibid.

101 Ibid. Olive Irwin, Tape recording.

102 Erickson, *Notebook*.

103 Erickson, *Notebook*; Ruby Bowman, *Notebook*.

104 Violet McMillan, Tape Recording. The bell now holds a privileged position within the WGHAA Archival display.
Myrtle Crawford, Tape Recording; Isabel Cameron, Tape recording; Ingibjorg Cross, interview by author, Tape recording, Vancouver, B.C., 20 July 1988.

The exact hours of classes shifted according to the subject area, seniority of student, and time of year. See for example Vera Chapman, interview by author, Tape recording, Winnipeg, Manitoba, 2 July, 1987; Beryl Seeman, Tape recording.

Violet McMillan was convinced of the efficacy of hot milk "it might all be in your head but it works." Violet McMillan, Tape Recording. See also, Mabel Lytle, interview by author, Tape recording, Winnipeg Manitoba, 30 June 1987.

This description was created out of the combined interviews with WGH graduates. It confirms the descriptions of daily schedules related to me by graduates of training schools in Vancouver, Brandon and Halifax.

One nurse tells of a patient requiring a doctor's order to sleep with the blankets untucked. Violet McMillan, Tape recording.

Winnipeg General Hospital, Reports and Accounts, 1921, p.16.


WGH, Reports and Accounts, 1918-1922. The relationship between nurses and hospitalized veterans on WGH's "D flat" appears to have been somewhat special, and one which re-emerged after World War II between a new generation of nurses and veterans. See for example, Jessie Law, interview by author, Tape recording, Vancouver, B.C., 1987; Olive Irwin, interview by author, Tape recording, Winnipeg, Manitoba, 3 August, 1988; and Grace Parker, interview by author, Tape recording, 25 June 1987. Grace Parker, Tape recording.

Ibid, 1924, p 11-12.
In her study of work reform in American nursing, Susan Reverby concluded that for all the efforts to introduce time management into nursing practice "scientific management was ...more rhetoric than reality in the hospitals in the first half of this century." Susan Reverby, "The Search for the Hospital Yardstick: Nursing and the Rationalization of Hospital Work," in Susan Reverby and David Rosner, *Health Care in American: Essays in Social History* (Philadelphia: Temple University Press, 1979). At both WGH and Vancouver's VGH emphasis was placed on reorganizing wards rather than through restructuring nursing practice.

Susan Porter Benson, *Counter Cultures: Saleswomen, Managers and Customers in American Department Stores, 1890-1940* (Urbana: University of Illinois Press, 1986) makes a similar argument with respect to the experiences of salesclerks.

Susan Porter Benson, *Counter Cultures*.

Olive Irwin, Tape recording.

WGH House Committee, *Minutes*, 17 October 1921, reported that three intermediate students who had done poorly in exams the previous year were demonstrating "unsatisfactory" ward work and were asked to withdraw.


Grace Parker, Tape recording.

Myrtle Crawford, Tape recording.

Mable Lytle, Tape recording.

Nurses "went to bed one night" as a student and "woke up the next day" as a graduate nurse. Beryl Seeman, Tape recording.

Harriet Pentland, Tape recording.
125 W. A. Biglow to Wilma Mitchell, 19 June, 1937. Wilma Nicol Collection, Brandon, Manitoba.


127 S. E. D. Shortt, "Before the Age of Miracles" in Roland, Charles G. ed. Health, Disease and Medicine: Essays in Canadian History (Canada: Published for The Hannah Institute for the History of Medicine by Clarke Irwin Inc. 1984) describes the limitations on rural medical practice in the pre 1950 years.

128 Ingibjorg Cross, Tape recording.

129 Myrtle Crawford, Tape recording.

130 Cali Dunsmuir, interview by author, Tape recording, Vancouver, B.C., 1986. Given the danger of anaesthetics, nursing technique for "Putting an Anaesthetized Patient to Bed" was time-consuming: "Take and record pulse every fifteen minutes for the first hour, then hourly to the fourth hour...Then every four hours until normal." Violet Erickson, Notebook.

131 Mary Shepherd, Tape recording.

132 Ibid

133 Myrtle Crawford, Tape recording.

134 Ibid.

135 Ibid.

136 Beryl Seeman, Tape recording.

137 Mary Shepherd, Tape recording.

138 Mary Duncan, Tape recording.

139 Myrtle Crawford, Tape recording.
140 Some supervisors provoked intense and long-standing animosity in their subordinates. See for example, Anne Ross, interview by author, Tape recording, 4 August, 1988; and Cali Dunsmuir, Tape recording for descriptions of negative student-supervisor relations.

141 Barbara Keddy, et al, "Nurses' Work World: Scientific or 'Womanly Ministering'?," Resources for Feminist Research, 16, no. 4: p. 38. In another article Keddy asserts that "the role of every nurse in that era was primarily that of housekeeper", a statement that contradicts all the evidence to the contrary she herself presents; See Keddy, "Private Duty Nursing Days of the 1920s and 1930s in Canada" Canadian Woman Studies, 7, no. 3: pp. 102.

142 Whether inspired by patient-demand, or medical advice, hospitalization for health services became the predominant mode in the interwar decades. See Strong-Boag and McPherson, "The Confinement of Women" in Jean Barman and Robert A. J. McDonald, Vancouver's Past.

143 This was particularly true on the large public wards serviced by limited intern and consulting staff. See Chapter 4.

144 Braverman, Labor and Monopoly Capital, pp. 51-52, 113-114.


147 Ibid, p. 302.

149 See Chapter 4 for a discussion of nurses' reasons for entering training, and their frequent financial reliance on nursing throughout their lives.

150 Susan Porter Benson, *Counter Cultures*.


152 Harriet Pentland, Tape recording.

153 Mary Shepherd, Tape recording.
Chapter 6
"Trade Unionism of the Worst Type":
Nursing Organizations and Women's Work

Like many working women of their day, the third generation of Canadian nurses utilized a variety of individual forms of resistance to improve their working conditions. Nurses confronted patients, doctors, and administrators, and allied with the same groups to play off one against the other, or all. Nurses left jobs; they left town; they left the occupation. Unlike most working women of their day, however, nurses also developed a collective voice to articulate their needs. The organizations which Canadian nurses created and sustained reflected the structure of their work, and the occupational identity born of it. Borrowing from the organizational strategy of professionals, and the activities of unions, nurses established a unique series of corporate vehicles which have survived the dramatic transformation of health services in the twentieth century.

This chapter documents the extensive network of associations serving nurses' interests during the 1920s and 1930s. Within these groups, third generation nurses were introduced to first and second generation Canadian nurses, to the political issues confronting the occupation, to the occupations' organizational structure, and to the legacy of service they inherited. The occupational identity nurses learned on the job was reinforced in their associational activities. During the interwar decades, nursing organizations also became the site of internal conflict, as private duty nurses challenged the
occupation's leadership over proposed solutions to the economic crisis of the private sector. Associations were pressured to address immediate workplace issues, rather than long-term professional goals. This threat to organizational unity prompted nursing leaders to propose and endorse hospital employment of graduate nurses, and the abolition the apprenticeship system of staffing. Thus the actions and attitudes of working nurses, their agency, proved to be a critical factor in the transformation of Canadian hospitals. At the same time, the internal conflict over organizational strategy, and the willingness of private duty nurses to employ trade union tactics, revealed the third generation's limited adherence to the ethic of "large P" professionalism.

From the international to the local, five levels of associational activity existed to unite graduates of Canadian training programs and defend their interests. The International Council of Nurses (ICN) assembled representatives from nurses in Europe, North America and beyond, in a series of formal and informal gatherings culminating in highly publicized Congresses. The Canadian Nurses' Association (CNA) united graduates of approved training schools via biennial meetings, communication with provincial representatives, and publication of the Canadian Nurse. Provincial organizations such as the Manitoba Association of Graduate/Registered Nurses (MARN) carried the legislative authority to define credible training programs and to confer "Registered Nurse" (RN) status upon individual members. Urban centres across the nation boasted
graduate nurse associations designed to serve the interests of local practitioners. Hospital alumnae associations in contrast represented all graduates of individual institutions, regardless of where, or if, members were working. Finally, a sixth type of organization also emerged in the 1920s. Training School Student Councils, composed of elected representatives from each graduating class with presidential status reserved for senior students, provided apprenticing nurses with a vehicle through which to express their concerns. Thus, from their first days of hospital training, aspiring nurses were involved in the myriad of organizations designed to reinforce their collective identity, and were exposed to the concept of self-government which all graduate organizations embraced.

Six common features characterized the organizations that mobilized nurses. First, the majority of associations were established during the two decades from 1900-1920, and drew the bulk of their initial membership from the growing numbers of second-generation graduate nurses. The original leadership elite, however, often came from women trained in the late nineteenth century, and thus the second characteristic shared by Canadian organizations was the strong influence of pre-suffrage feminism. Ethel Johns credited the "great upward surge of the woman's movement ... dragging me unresistingly into its current" for her initial involvement in nursing organizations. Nursing associations generally supported, and were supported by, feminist groups such as Local and National Councils of Women, the YWCA, and the United
Farm Women. For many such female activists nursing pioneers symbolized their goals of female independence, authority and dedication. Nurses drew on such sympathies for support when they campaigned to improve their status. A third common feature lay in the important and often closely intimate relations with various international nursing groups and their representatives maintained by all levels of Canadian organizations. International influences were enhanced by efforts of prestigious ex-patriot Canadians such as Columbia University's Isabel Maitland Stewart, and high-profile immigrants to Canada such as Ethel Johns. Fourthly, despite the continuing influence of American developments in the health care and nursing field, the collective endeavours of Canadian organizations remained distinctive in that they overlapped but did not compete for recruits and loyalty, as did nursing associations in the United States. A strict vertical integration was maintained through the careful adherence to jurisdictional powers of each level. Two organizations deviated from this general rule. National and local sororities of nursing sisters, formed after World War I, accepted only veterans of military service, while in 1925 the "First Convention of Canadian French Speaking Nurses" united Francophone practitioners, predominantly from Quebec, and resulted in the founding of the monthly journal La gardes malade canadienne française. While these new bodies to some degree competed with the previously established agencies, cooperation rather than challenge characterized their interaction. Both the military and
Francophone groups integrated their activities with those of provincial and national organizations, and both utilized the Canadian Nurse as a vehicle through which to keep all Canadian nurses apprised of their work. Thus the two were exceptions in form rather than function to the integrationist pattern within Canadian nursing organizations.

The fifth, and in some ways most significant, characteristic of nursing organizations was membership policy. Like their sister organizations in other countries, nursing associations were occupationally specific, gender specific, and open to any graduate nurse, regardless of rank. For obvious reasons Alumnae associations and Student Councils were the exception to this rule, representing only those affiliated to their hospital. In general, however, whether she was engaged in a private, public, hospital, military, or industrial position; was unemployed or had retired; as long as appropriate credentials could be demonstrated, any nurse could actively participate and throughout her life share in a powerful professional and sentimental community. The inclusive membership structure determined the sixth and final common feature of nursing associations, their function. Organizational committees created to serve the plurality of interests and needs present within the nursing community took on tasks ranging from legislative lobbying, to educational programs, to social events, to establishing employment policies. In particular, in almost all nursing associations standing committees for "Private Duty", "Public
Health" and "Nursing Education" addressed the diverse interests of specific sub-fields. Leaders of each section brought forward an array of problems and proposals to the general memberships of the associations in an effort to ensure the interests of their particular group were being served. In this way private duty nurses, who because of their mobility and independence were all too easy to lose contact with or to alienate, had a separate and formal voice designed to ensure their representation.

The plurality of interests represented at each level was accentuated by the fact that not all practitioners enjoyed the resources to volunteer for associational responsibilities. The rank-and-file working in the uncertain private market found it particularly difficult to attend meetings or take on committee duties. In contrast, salaried positions in training schools or public health agencies not only permitted scheduled time-off, but employers often encouraged their nursing staff to attend professional events. This produced an imbalanced representation in leadership positions, with hospital training school staff and public health nurses filling more than their share of positions. Private duty nurses were also numerically under-represented on executives and boards. As long as the tension between these two opposing forces -- tradition and structure pulling nurses together and diversity of interest and experience separating them -- was balanced, the organizational system worked. The lessons learned from the lengthy campaigns for provincial nursing legislation, and its attendant
social legitimacy, reinforced the conclusion that opposition to nursing self-regulation on the part of male politicians demanded all the collective strength nurses could muster. If they wished to gain legislative self-government, nurses and their organizations could not afford to let divisions among different kinds of practitioners get out of control.

As the political struggles over provincial registration which dominated the 1900-1920 years were eclipsed by economic problems the tension between design and function shifted. During the interwar years, nurses working in the sector hardest hit, private duty, turned to their collective representatives for solutions to dangerous working conditions and debilitating unemployment. Demanding improvements over work in the private sphere involved challenging doctors, patients and medical administrators, and potentially the "dedication to service" credo which nursing leaders had promised the community and upon which nurses' identity was formed. And yet the conditions under which most worked required immediate solutions if rank-and-file nurses were to continue to share the vision of nursing which earlier generations believed was necessary for their sex to advance. In their common organizations, the representatives of private duty nurses pressed superintendents to use their institutional authority to influence doctors and patients on behalf of nursing's majority. For their part, nursing administrators struggled to ameliorate hospital employment
conditions which threatened the health of their students, the popularity of their programs, and the image of their occupation.

Lacking any real authority in the private home where many graduates laboured, nursing superintendents proposed solutions to their occupational problems at the point of production of workers, rather than at the point of production of patients. Nursing educators in the 1920s and 1930s believed that a compromise solution existed which would stabilize graduate employment and release nursing education from its indenture to the hospital. That compromise was the eradication of the apprenticeship system of staffing. While this did not meet the demands of those nurses who continued to prefer the private duty sector and resisted the model of post-graduate employment in the same institutions which had dominated and exploited them as students, such solutions did convince nursing's majority that the organizations designed to represent them were sincerely seeking solutions to the economic crisis. Ironically, however, this emergency response, not only aided and ensured the shift to highly centralized institutional health services, which came to predominate in the post-World War II era, but guaranteed the final step in the proletarianization of nurses. In the last years of the Second World War, the creation of large staffs of waged-practitioners working for a centralized employer in factory-like conditions would fracture both the identity and the unity of the occupation's organizations and identity, the very breakdown which the third generation of Canadian nurses was trying so hard to avoid.
During the first half of the twentieth century, the strength to survive conflict and prevent competition lay in the traditions and structures which connected the various associational forms. From their inception these organizations were mutually dependent, but each operated from slightly different bases of power. Canadian participation in the ICN exemplified the close connections among local, national, and global movements and indeed between nursing and feminist pioneers, who were sometimes one and the same. The ICN was formed in 1899 under the auspices of Mrs. Bedford Fenwick, President of the British Nurses' Association. For close to a decade, Canadian women participated informally in the International Council's deliberations. Not until 1908, did Mary Snively, Superintendent of the Toronto General Hospital (TGH), call the executive committee of the newly formed Canadian Society of Superintendents of Training Schools (CSSTS) to discuss the creation of a national nursing organization so that Canada could be represented officially at the 1909 meeting of the ICN in London. The resulting organization, named the Provisional Organization of the Canadian National Association of Trained Nurses, forerunner of the Canadian Nurses Association (CNA), paved the way for twenty-five Canadian delegates to attend the 1909 meetings. Canadian involvement in the international association continued throughout the 1920s and 1930s, highlighted by the invitation to hostess the International Congress scheduled for 1929. That July, 7000 ICN representatives from 34 countries met in Montreal "much to the
bewilderment of the citizens who were not accustomed to seeing hundreds of nurses on the streets in European outdoor uniforms or the native costumes of their homelands."16 Issues of the 1929 Canadian Nurse publicized the multinational celebration, and provided for its readership, the majority of Canadian practitioners who could not attend, details of the various sections, lectures and discussions.17

Through their representatives, who were active in the international agency, the CNA rank-and-file insisted that participation in the ICN benefit all working nurses, not just the interests of the national elite. When in 1928 CNA representatives suggested that the unused dollars of the CNA Memorial Fund, money collected after WWI for the purpose of a permanent memorial to nurses' wartime contributions and losses, be put towards membership fees for the ICN, their proposal was defeated. Instead the CNA executive was instructed to utilize the funds in a way "which will be of benefit to the whole of the nursing profession."18 Two years later, rank-and-file members again exercised their democratic rights when the Private Duty Section recommended to the CNA General Assembly that "the Private Duty Section of the International Council of Nurses should be nurses actively engaged in private duty nursing....19 Similarly in 1932 when ICN Private Duty Section Convenor Miss Isabel MacDonald requested information concerning nursing conditions in Canada, the Canadian section responded with pride that "Private Duty Sections in Canada, whether
Thus, while the very existence of the ICN had prompted the creation of a Canadian graduate nurse organization by elite nurses, once established, rank-and-file nurses demanded a hearing not only at home but abroad as well.

Important as the ICN was in uniting nurses from all continents, throughout the 1920s and 1930s most political involvement took place on North American soil. The first nursing organization to which Canadian nurses belonged was the American Society for Superintendents of Training Schools for Nurses (ASSTSN). Conceived at a meeting of the "Hospital, Dispensaries, and Nursing Section" of the International Congress of Charities, Corrections and Philanthropy held during the 1893 Chicago World's Fair, the Society united Canadian and American administrators under the slogan celebrated by many feminists "organization is the power of the age, without it nothing great is accomplished." In 1907, Canadian superintendents formed an autonomous organization, the CSSTS, (later named the Canadian Association of Nursing Education, CANE), which one year later created the Canadian Association of Trained Nurses to promote the interests of trained or graduate nurses. The two organizations remained cooperative but independent until June 1924 when, at the CNATN's 12th Annual Meeting held at the Royal Connaught Hotel in Hamilton, 332 "delegates, members and visitors" agreed to merge the CANE with the CNATN and to form the Canadian Nurses' Association (CNA).
CANE rationale for amalgamating, "that there might be a more central national body of nurses functioning in the interests of nursing education," indicated that in subsuming their identity within the larger group nursing educators had no intention of abandoning their traditional focus on training and its problems.23

Even after the associations united, the distinct needs and character of superintendents and graduates continued to inform the structure of the national body. From the onset, three sections addressed the distinctive interests of Superintendents, Private Duty Graduates and Public Health Nurses. Each group was responsible for electing a convener and an executive.24 Conveners chaired the section meetings held as part of the biennial CNA general conventions. Out of these in turn came resolutions to the General Assembly. Voting powers at the General Assemblies were determined provincially, according to the size of the nursing population. Individual nurses could participate in all convention discussions, and were free to join any section, though voting divisional powers were reserved for provincial delegates. With exception of Quebec which was permitted two delegates per section, one to represent French-speaking and one to represent English-speaking nurses in that province, provincial associations sent one delegate per section. Between national conventions, section executives and provincial representatives were charged with monitoring issues pertinent to their members, and
contributing material pertaining to their membership to the Canadian Nurse.

Graduate nurses became members of the CNA either through registration with provincial organizations, graduate associations of individual cities, or alumnae associations. Figure 6.1 lists the original members of the CNATN.25

**Figure 6.1**
Original Members of the CNATN

The Canadian Society of Superintendents of Training Schools for Nurses
The Graduate Nurses Association of Manitoba
The Graduate Nurses Association of Ontario
The Graduate Nurses Association of Calgary, Alta.
The Graduate Nurses Association of Edmonton, Alta.
The Graduate Nurses Association of Hamilton, Ont.
The Graduate Nurses Association of Ottawa, Ont.
The Graduate Nurses Association of Vancouver, BC
The Graduate Nurses Association of Montreal, PQ
The Alumnae Association, General and Marine Hospital, Collingwood, Ont.
The Alumnae Association, General Hospital, Kingston, Ont.
The Alumnae Association, General and Marine Hospital, St. Catharine's, Ont.
The Alumnae Association, General Hospital, Toronto, Ont.
The Alumnae Association, Hospital for Sick Children, Toronto, Ont.
The Alumnae Association, Riverdale Hospital, Toronto, Ont.
The Alumnae Association, Western Hospital, Toronto, Ont.

Source: Canadian Nurses Association

The significance of the alumnae groups was suggested in 1907 when the Toronto General Hospital Alumnae Association *Journal* was
transformed into the national publication, the *Canadian Nurse*. By 1924, when the national body was reorganized and renamed, it represented 37 "federated associations" which included provincial associations, local organizations and alumnae groups. Each affiliate submitted reports of their activities to the biennial conventions.

The original structure meant that nurses could be members through both a provincial and an alumnae group, but in 1928 the question of "dual membership" was raised. Much discussion followed the recommendation that "the objective of the CNA was to obtain membership through the provincial organizations only." Two years later the committee charged with studying the question presented a report endorsing a changed membership structure. Committee convener and representative from Ontario, Florence Emory, "stressed the strengthening of the provincial associations and the adoption of one standard of membership for provincial and national organizations." Nova Scotia and New Brunswick agreed, pointing out that in those provinces no alumnae associations were affiliated so CNA membership was through the provincial associations already. Provincial representatives all assented, as did most affiliated alumnae groups. Only the Winnipeg General Hospital (WGH) Alumnae voiced dissent, but despite its reservations did not break rank with the majority opinion. In 1930 dual affiliation was eliminated.
The decision in favour of provincial associations appeared a deliberate manoeuvre to strengthen a weak link in the nursing hierarchy. By way of contrast, the apparent losers, such as the hospital alumnae groups, were flourishing. By 1920 alumnae associations existed for every large, and most small, hospital nursing programs in the Dominion, and new schools almost always followed suit. For an annual fee, graduates secured memberships in their alumnae society and with it the right to participate in the social, educational, political, archival/historical, and economic activities of the association. Large numbers of active and inactive nurses contributed funds and enthusiasm for projects as diverse as sick-benefit funds, furnishings for the nurses' residence, receptions for incoming nursing superintendents, scholarships, nursing missionaries in India and China, memorials for nursing's wartime casualties, cards and flowers to sick members and their families; drama and choral groups; bedding and supplies to poor families; archival collections, and bandages and supplies for the Red Cross. At monthly and annual meetings, various committees reported on their assigned projects, followed by some kind of social or educational event. Initial organizing was not always easy. Ethel Johns recalled the formative years of the WGH Alumnae group.

It struck me then that there was something gallant about the attitude of these women, who met month after month only to find that few were interested enough to put in an appearance.
The involvement of new graduates like Johns contributed to the success of alumnae endeavours and the momentum carried. Each year a new executive was elected, and active involvement of the hospitals' nursing superintendents guaranteed direct communication to the hospital administration, as well as a source of information about hospital developments.34 While some consultation between alumnae and their alma mater lacked momentum, other alumnae endeavours carried greater significance. When, in 1932, the Vancouver General Hospital (VGH) Board of Directors considered admitting Japanese and Chinese students into the Training School, alumnae endorsement paved the way for this critical policy change.35

Members not in attendance at alumnae meetings were apprised of the activities of both their association and their peers through various publications. Alumnae newsletters, journals and magazines served as important communication points for nurses working on all continents. "Class reps" were responsible for establishing updated mailing lists of their peers, and much of the alumnae energy went into recruiting, and maintaining, members. This process of affiliation started with strong alumnae involvement with nurses still-in-training. Most alumnae associations hosted a graduation event for their school, and publicized their work amongst the students before they graduated and scattered to the four winds. For instance, beginning in 1920, the WGH Alumnae Association honoured each graduating class with a dinner, and took an active part in
commencement exercises. Banquets held at elegant hotels such as the Royal Alexander and Marlborough brought old and new graduates together to reinforce old ties and create new ones.

For their part, instructors ensured that students received apprenticeship training in the system of nursing organization as well as nursing work. Winnipeg General student Viola Erickson's assignment entitled "Organizations" reiterated lessons learned:

Each large training school has an Alumnae Association. No matter how big or small an organization may be, the Alumnae Association is the foundation of it. It is also the connecting link between the school and the profession.

WGH Superintendent Kathleen Ellis rewarded Erickson's perception of organizational life with an "A-". To provide experience in collective activities, administrators and organizational leaders endorsed the concept of student representation. Student councils were established in all major training schools, while the Canadian Nurse reserved space for contributions devoted to descriptions of student activities. The VGH Student Council, formed in 1918, was one of the first of such groups. Elected representatives from each class of VGH student nurses met with the Director of Nursing and her supervisors to discuss the interests and needs of the nursing staff. When in 1933 the Director of Nursing proposed a reduction of students' monthly "salary" from $6, $8, and $10 to $5, $6 and $8 she "[introduced] the subject of cuts to the Student Council for the purpose of securing their re-action to the same." During World War
II Japanese students at the VGH were informed they they could not finish their training, and the Student Council was the vehicle whereby nurses protested, in vain, against the expulsion of Japanese women from their program.40 At most hospitals, from the early 1920s student representatives formalized nurses' workplace culture in print, annually publishing their yearbooks -- one of the few surviving types of records of student life.41

The yearbooks produced by senior nurses promoted bonds between members of each graduating class even after they were long away from institutional life. Even the concept of a graduating class -- itself somewhat arbitrary given the staggered dates of entry into many programs as well as the extended completion dates of nurses ill during training -- provided alumnae associations with a tool to recruit and retain members. At the 1938 Jubilee celebrations of the WGH School of Nursing's fiftieth anniversary, the WGH Alumnae Association possessed mailing addresses for 1400 of the 1781 graduates of the school, of which 600 attended the week-long event.42 Many of those absent from the festivities were dead, infirm, or lacked the resources to return for the week, and doubtless many others were disillusioned with their alma mater and/or alumnae group.43 As the attendance of over one-third of graduates demonstrated, alumnae associations held nonetheless a significant presence among nurses. Lacking any legislative authority, alumnae associations relied on voluntary membership and personal networks. To maintain a strong base of support they had to demonstrate
regularly their relevance. On the front-lines of nursing issues, alumnae groups were often the first to respond with material assistance to members in need, and it was this sensitivity to the "here and now" of nurses' work and personal lives which kept these organizations viable and strong.

Of course, as nurses moved away from the town or city of their alma mater, they benefited from fewer of the services alumnae groups offered. Thus, to unite nurses regardless of educational background, graduate nurse associations or clubs emerged in many urban areas. These groups provided many of the same services as the alumnae associations, followed the same organizational structure and along with many alumnae groups were some of the earliest affiliates of the CNA. Like the alumnae bodies, local graduate nurses' organizations enjoyed grassroot support from active and inactive nurses, and from local nursing administrators. The Graduate Nurses Association of Montreal for example was formed in 1917 under the presidency of Grace M. Fairley, Superintendent of the city's Alexandra Hospital, and secretary Mabel F. Hersey, Superintendent at the Royal Victoria Hospital. Local organizations continued to flourish playing particularly important roles for women in small and remote centres. The northern town of Flin Flon sponsored a nurses' association which provided immigrants from the south such as Florense Polson with an immediate welcome to a community of like-minded women. Dedicated to improving the status of their
occupation, these organizations were strong supporters of legislative solutions to nurses' workplace problems. Since legislative authority lay at the provincial level, local groups worked together to form provincial organizations.

Among the earliest initiatives taken to organize provincially were those taken by Ontario nurses. Credit for the formation of the Graduate Nurses' Association of Ontario (later the Registered Nurses' Association of Ontario, RNAO) is granted to Mrs. Agnes Pafford, a first generation pioneer. According to official RNAO history Pafford worked as a nurse only a short time before retiring into marriage, but maintained a strong interest in her occupation. Inspired by the 1901 ICN meeting in Buffalo, New York, Pafford "wrote personally to the Superintendent of every training school in the province on the subject of Registration, urging Alumnae organization as a necessary preliminary step, and asking for a list of graduates with whom she also communicated."47 Not only did her enthusiasm prompt the inception of many alumnae associations, but in 1904 a provincial organization was "attempted." Its success led to the creation of chapters in regional centres, first in Hamilton (1908), and then in Brantford, Kingston, Ottawa, Owen Sound, Peterborough, and Toronto.48

Meanwhile, similar agitation in other regions resulted in the formation by 1920 of nine provincial bodies, each with strong ties to smaller units operating at the local level. The Graduate Nurses
Association of Nova Scotia (Registered Nurses Association of Nova Scotia, RNANS) was conceived in 1909. The Graduate Nurses Association of British Columbia (RNABC) established in 1912 by members of the Graduate Nurses Association of Vancouver, the Victoria Nurses Club, the Graduate Nurses Association of New Westminster, and representatives from Kamloops. In Manitoba, local groups in Winnipeg, Brandon, and Flin Flon worked together to maintain the Manitoba Association of Graduate Nurses. The Montreal group succeeded in establishing a provincial body in 1920, prompting a series of negotiations with a parallel and competing organization operating out of Quebec City.49

Created by city and alumnae groups to confront the political system to which all women still had limited access, provincial associations across the Dominion echoed the goals espoused by the CNA and ICN, and placed the achievement of legislative authority first on their agenda. This plan of action was designed to win self-government for nurses, and with it social legitimation of nurses' rights to determine the qualifications defining graduate nurse status. The concept of self-government was perfectly consistent with the larger program of reform endorsed by Canadian feminists, who enjoyed material and political support from their sisters in nursing. The close connection between political and legislative reform was revealed by a 1917 resolution from the GNANS that the Maritime group:
...put themselves on record and approve of the advisability of granting the franchise to women of the Province of Nova Scotia. Knowing that this is a work in which women and men, whether organized for suffrage or the moral and social welfare of the people are interested, we decided not to dissipate our energies trying to form new societies, but to work as far as possible through existing nursing organizations and other organizations of women and men favourable to the cause and that this committee do earnestly strive to bring about the cause of suffrage by working along the line of political education.50

In Manitoba, the formal participation of their associations brought nurses direct involvement with the Local Council of Women, the Ukranian Women's Council, the United Farm Women of Manitoba, the Professional and Business Women's Club, the Central Council of Social Agencies, the Junior Red Cross, the YWCA, and the "New Canadian Girls. Communication with women's organizations kept nurses conscious of gender politics. For example, at the September 1935 Quarterly Meeting of MARN, members learned that in July of that year Judge Helen Gregory McGill had been honoured by the Winnipeg Local Council of Women. At that event McGill had spoke to the "national status of women in Canada" and

...urged more interest in politics, intelligent exercise of the franchise, the need of women in national affairs, and stated that forty thousand women yearly are losing their nationality in Canada due to ignorance of the fact that they must apply for naturalization papers, as their husbands do.51
McGill's emphasis on the amount of work "that only the women of Canada could do" was shared by the Manitoba nurses actively involved in feminist organizations. In some instances, MARN sent delegates to meetings of other women's groups, and in other instances merely provided a voice of support for a political or economic gain for women. For example, in April 1933 WGH Superintendent Kathleen Ellis was appointed to serve as the MARN representative on a delegation of women being assembled by the Professional and Business Women's Club to lobby Premier Bracken concerning female members being appointed to the Board of Governors at the University of Manitoba.52

In return for their assistance, nursing organizations enjoyed essential support from other women's groups.53 Houses owned by Local Councils of Women and facilities run by the YWCA, gathering places for many women's groups, were donated regularly as meeting space for local nursing committees, while the National Council of Women assisted the fledgling provincial nursing groups with their initial legislative proposals.54 Even the national nursing journal drew on the expertise of early feminists. When in 1907 the TGH Alumnae Journal took wings as the Canadian Nurse, "no nurse could be found who had the requisite experience to act as editor," and Dr. Helen MacMurchy filled the position until 1910 when nurses Bella Crosby, and then Helen Randal took charge.55 Connections among women's organizations and nursing associations, and among the
various levels of nursing groups were often created, and usually strengthened by powerful individuals who emerged as the profession's leaders in the interwar years. The careers of Ethel Johns and Isabel Maitland Stewart, for instance, illustrate the weight with which such individuals united the various levels of organizational activity from the training schools through the upper echelons of international nursing.56

Even with appeal from nursing associations, women's organizations, and high-profile individuals like Johns and Stewart, legislative successes came slowly. Although nurses in all nine provinces managed between 1910 and 1922 to have nursing legislation of some kind placed on the books, (see Figure 6.2) most laws were weak and ineffective in granting self-regulation.57
Manitoba was the first province to achieve the desired "registration" legislation. On February 15, 1913, an Act of the Manitoba Legislature was assented to, founding the Manitoba Association of Graduate Nurses (MAGN). This Act empowered MAGN to set educational standards which would identify trained or graduate nurses. This rather toothless initiative was amended in 1920 to grant MAGN power to accept nurses registered in other provinces, states or countries to register in Manitoba without writing the Manitoba exams, and to grant a "Trained Attendant" certificate to anyone receiving six months training in approved hospitals. Further
amendments in 1923 permitted the provincial body to raise the educational standard for training schools from five beds, to twenty, and students had to be trained and supervised by a nurse registered with MAGN. Only those with one year high school and a diploma from an approved training school could call themselves graduate nurses.58 The most important change of this era, however, occurred in 1929. Not only did this revised Act enable the Association to enhance its financial capabilities, and put in place examinations at the University of Manitoba, but allowed the name Manitoba Association of Registered Nurses (MARN) to be used. While each of these legislative additions were considered a victory, they only empowered nurses to define who could call themselves a trained, or graduate or Registered nurse.59 Provincial legislators would not permit nursing organizations punitive authority over untrained personnel "practicing nursing", such as that granted Medical associations to limit who had the right to "practice medicine".

For all the energy they consumed, these legislative battles provided a raison d'etre for provincial organizations. Created to conform to Canada's federal-provincial distribution of power, provincial associations continued to rely on alumnae and city organizations for grassroot support, and never gained the legislative strength their national authors envisioned. The campaigns to achieve legislative self-government did, however, reinforce the importance of the collective strength based on inclusive membership structure. Thus, as economic problems beset the rank-and-file of
nurses working in the private sector, nursing associations at each level of organization were forced to address questions of working conditions, unemployment and member services, or lose their basis of support. While third generation nurses remained true to the integrated organizational system which had been established in the pre-1920 years, these economic problems faced by rank and file nurses provoked internal organizational dissent and conflict over the nature of nursing organizations and of nurses' collective identity. Debates around how to improve hours, wages, creation and distribution of private duty work within the CNA, the Winnipeg General Hospital Nurses' Alumnae Association, and the Manitoba Association of Registered Nurses exemplified the divisions among nurses, and their efforts to resolve those differences.

Notes of discord could be heard within the Canadian Nurses Association as early as 1921. Ironically, they were struck by Ethel Johns, one of Canada's most politically-conscious practitioners. In February of that year Johns presented a paper which claimed that private nurses "had nothing to say for themselves." Given her record, and given that Johns considered herself a private duty nurse at the time, her words were likely meant as a challenge to nursing's majority to articulate their experiences and opinions. One did. In March 1921 a letter to the Canadian Nurse from an anonymous "Private Nurse" responded to Johns, directing her and other superintendents to
...clean their own steps. Never have I seen such mean unprincipled things done as I have known to be done by superintendents....61

Citing a tale wherein a student nurse had been expelled from a training program two months before her graduation because the superintendent had overheard the student's friend say "It is five to ten, so I must let you go in or the Old Cat will be at you again," the anonymous critic went on to discredit the nursing experiences of most superintendents.

At our conventions I have had ample opportunity to see how little the self-promoters really knew about the actual work....No wonder you [Johns] allude to the pathos and bathos you passed through [in the past year of nursing] no doubt, you had all of half-a-dozen patients, five mild and one serious. What thrills you must still have. Now do tell us something about it at the next convention, and then we privates will be able to say, it truly is a nurses' convention, for some one did say a word about nursing this year....62

This letter, the most blatant critique of anything or anyone to be printed in the first fifty years of the journal, provoked a series of responses demanding among other things, a signed apology from the author and the end to anonymous contributions. Private nurse Annie Kennedy Vancouver, BC was among those most incensed that,

Anything pertaining to the subject of private nursing, so remote from the work, so misleading, so petty and so utterly crude,
should have found its way in among the regular thought-toned articles of our National Nursing Journal".63

When Canadian Nurse editor Miss Helen Randal, herself a former Lady Superintendent of the Vancouver General Hospital, refused to publish the anonymous author's name, Kennedy ended her 12-year subscription to the journal.64

While the rough-and-tumble over professional ethics and public criticism raged65, a more measured voice of dissent arose. That voice belonged to Toronto nurse, Edith Gaskell. The 1920 convention had been Gaskell's first. She and her four private duty companions had eagerly anticipated an inspirational message, but instead found that "the private duty nurse was the butt of the meeting." Comments such as those made by Johns that "many private duty nurses remained on cases much longer than required in order to draw large fees" (Gaskell reminded the CNA that the length of tenure on a job was "usually not settled by the nurse")66 prompted Gaskell to become involved in CNA sectional politics. The following year Gaskell returned to the national meeting, this time as Convenor of the Private Duty Nursing Section, and immediately raised the question "[is] there not a little tendency to criticize the private duty nurse?" Acknowledging that members of her Section were too often "inarticulate," an understated Gaskell began:

It will... not be unfitting that a humble, private duty nurse of long experience, speaking for her sisters in the profession, on the necessity, desirability and utility of
organization, should ask you to consider for a little while the reasons for the silence and ineffectiveness of the private duty nurse.

Gathering steam, she observed:

The reasons are very clear to the nurse herself and should be easily comprehended by others. Long hours of labour of the most exacting and exhausting nature are disastrous to clearness and originality of thought, and the absolute lack of time for much-needed recreation, proper reading, religious exercises and social intercourse, which privileges the other branches of the profession enjoy to a far greater extent than does the private duty nurse, are not calculated to be productive of any very valuable or enlightening assistance from a body so handicapped.

No wonder Gaskell concluded that "with so many other occupations offering easier conditions of work," nursing was waning in its popularity as a career choice. The Convenor's report concluded with a further explanation of the "failure of the private duty nurse to express herself," ruefully noting that "the opinion of the five thousand private duty nurses of the Dominion has never been sought in any matter of real moment to their profession."67

Invited or not, private duty nurses continued to voice their discontent through their national section, and their national journal. Continued references to the "inarticulate" majority of nurses working in the private field, reflected anxiety over the dominance of the CNA executive positions by nursing superintendents and
recognition of their plight. Johns risked further attack in 1930 when she offered her "first-hand impression" of the 1930 CNA convention to the Canadian Nurse readership. "One of the happiest features of the convention" wrote Johns, "was the active participation of the younger group of nurses. They not only had the courage of their convictions, but also the ability to express them clearly and well." Amid veiled allusions to conflicts which arose at the meeting, Johns addressed the issues confronted by the Private Duty Section:

The nursing profession as a whole is passing through a difficult phase, and this group more than any of the others had had to bear the brunt both of criticism and of economic stress. Its members discussed their special problems not only with frankness and good sense, but with a complete absence of the bitterness which might well have been held excusable in their difficult circumstances....Watch the private duty nurses during the coming year. They not only know where they are going; they are on their way.68

For all the difficulties inherent in pulling together such a dispersed group of private practitioners, policies presented by the Private Duty Section revealed that their members knew what they wanted to achieve, -- a solution to the employment problems vexing the private market. It was the implementation of such policies which caused the problem. Johns' prediction that "constructive suggestions were put forward [by the private duty representatives] which, if carried into action, ought to show definite results before long,"69 soon proved overly optimistic as issues of working conditions, unemployment and
national registration tested the CNA's ability to defend the interests of its rank and file.

Under Gaskell's leadership, the question of hours dominated discussions of working conditions during the early 1920s. Presiding over the 1924 Private Duty Section meeting, the Convenor received reports of the provincial committees, and chaired the discussion. Out of the discussion came a series of resolutions which were presented to the General Assembly. These are noteworthy because of their force and clarity, and because they were re-presented in their entirety at the following two biennial meetings:

... whereas the undue length of the working day of the Private Duty Nurse is either forcing many such nurses into other branches of the profession, or out of the profession altogether and thus depriving the private duty body of experienced nurses, to the great detriment of the body... And whereas the length of the working day in any other profession than that of nursing, or in any other branch of the nursing profession, is not as great as is that of the private duty nurse... And whereas the continued overweariness due to long hours of the most exacting labour must inevitably result in a much poorer quality of service rendered to the sick... And whereas the private duty nurse knows that even a ten-hour day is too long for the kind of work she has to perform, yet because she realizes the difficulties under which hospitals carry on and because her desire is to disturb hospital management as little as possible...
Therefore be it resolved that the hours of duty for private duty Nurses in hospitals be from 8 a.m. to 6 p.m., and 8 p.m. to 6 a.m. The same hours to obtain in private homes where possible, at the discretion of the nurse.72

Responses to the resolution were mixed. Some members, like Miss McLelland of Montreal’s Royal Victoria Hospital, informed the assembly that "a similar plan was working out satisfactorily" at her institution. Miss Jean Gunn, Superintendent of the TGH and veteran CNA leader73, was less enthused about private nurses controlling work within the hospital, and disagreed with the hours of duty being "so definitely stated."

It was her opinion that the hospital still has the responsibility of supplying the nursing care for the sick and by co-operation between the hospital authorities and the private duty nurses some arrangements could be made whereby shorter hours could be planned74

Miss Gaskell simplified the issue, reminding her audience that all private nurses wanted was the 10-hour day. The resolution passed in its amended form, that nurses work "ten consecutive hours, beginning preferably at 8 a.m. or 8 p.m."75

Having agreed on the policy, a further motion determined its implementation. The Private Duty Section was empowered to send copies of the resolution to superintendents of nursing across the country. Boards of Directors were deliberately overlooked since it was feared that
...this motion presented to hospital boards would cause considerable criticism, possibly of an adverse nature, but by presenting the resolution to superintendents of nurses the latter could quietly put the experiment into effect.  

This decision placed the responsibility for negotiating the 10-hour day on the shoulders of nursing rather than medical or lay administrators. Some superintendents tried to accomplish this goal, but generally speaking, the 10-hour day continued to elude most private nurses. Advocates were undeterred. Resolutions endorsing reduced hours were presented at each biennial meeting between 1926 and 1930, embarrassing the Nursing Education Section whose members were clearly unable to implement the change. In 1928, the CNA Chair intervened in the stalemate by ruling:

that as identical resolutions were passed at the 1926 meeting...the resolutions of the Private Duty Section as presented today, July 7th, 1928, be deleted.

But the prospect of sectional conflict worried members of the Nursing Education group, and plans were made to rectify the "lack of communication" between the sections. The result was seen at the next convention when in 1930 Grace Fairley, career-superintendent and active participant in the Nursing Education group moved that year's 10-hour day resolution.

By 1930 superintendents in general had come to agree that the problems faced by private nurses were but a manifestation of the
larger problem affecting all sectors of the occupation. Armed with the interim report of the Weir survey, reduced hours became one part of a package of reforms designed to correct the exploitation of students, and the overproduction and underemployment of graduates.

Whereas there exists marked and increasing unemployment among nurses in all parts of Canada
Be it therefore resolved That the Nursing Education Section request the CNA to send a communication to all hospitals in Canada conducting schools for nurses, asking the boards of these hospitals to seriously consider the question of the supply and demand for graduate nurses within the boundaries of Canada before increasing the number of student nurses to meet additional nursing needs of the hospital, and that the policy of the employment of graduate nurses to meet these demands be adopted until such time as the unemployment conditions have been readjusted.81

This acknowledgment on the part of superintendents that the persistence of the apprenticeship system was not their fault and the recognition within the Nursing Education Section that lighter student workload would improve training programs prompted nursing educators to support the private duty platform. Shorter hours liberated students to study and learn; the work created could employ graduates. In British Columbia, the implementation of 8-hour duty provoked extensive discussion regarding strategies for enforcing the reduced working day.82 The same concern surfaced at every meeting,
with only minimal progress reported. In 1938, the General Assembly was reminded:

The question of shorter hours for nurses has been considered at practically every hospital and nursing meeting during the past twenty-five years, yet the majority of schools have been unable to put shorter hours into effect. If the Nursing Profession does nothing toward furthering a plan for an eight hour duty for nurses then it can be expected that labour groups will compel action by legislation. In nearly every province, legislation has been enacted to protect every type of person connected with the hospital except the nurse. If the Profession is not going to take a definite stand then organized nursing might as well stop talking about eight hour duty nurses.

This frank critique of the national association's inability to improve conditions referred not only to circumstances at the workplace, but also the availability of work for nursing's majority in private practice.

The financial difficulties being faced by private nurses were raised within the CNA in the early 1920s. And yet Gaskell's observations about the uncertainty of private work, and about the lack of remuneration granted experienced nurses, remained as true in 1939 as they had been when she made them in 1921.

...[the private duty nurse] must frequently be idle whether she can afford to or not, years of faithful labour win no recognition, and the skilled and experienced nurse, whose services
are eagerly sought for by patient and physician alike, receives no more remuneration than the most inexperienced graduate.84

Not surprisingly, "very practical" papers such as that presented in 1926 by Toronto nurse, Miss Caroline S. Ross on the subject of "Financial Saving for the Private Duty Nurse" were considered of great interest to the National Section.85 So too were discussions on schemes to redistribute private nursing work. Group and hourly nursing were first debated within the Private Duty Section. For example, in 1928 papers on these subjects by Dr. A.L. Lockwood of the Lockwood Clinic Toronto, and Miss Gray, Superintendent of the Colonial Hospital in Rochester, Minnesota, sparked extensive discussion.86

By the late 1920s, the issue of private duty unemployment engaged all sections. Anticipating the conclusions of the Weir Report, the 1930 meeting of the Nursing Education Section proposed that a committee composed of members from each section be struck to investigate the most effective method of implementing group nursing for patients with limited means. It also proposed that the CNA write to all training schools in the Dominion, requesting that:

Boards seriously consider the question of the supply and demand for graduate nurses with in the boundaries of Canada before increasing the number of student nurses to meet the additional needs of the hospital, and that the policy of the employment of graduate nurses to meet those demands be adopted until such
time as the unemployment conditions have been readjusted.\textsuperscript{87}

With the full recommendations of Dr. Weir in hand, the General Assembly of the 1932 CNA convention took a much stronger stand. Sessions on "The Approved Training School", "Analysis of the Cost of Nursing Education" and "The Distribution of Nursing Services" resulted in a series of resolutions empowering the CNA to contact Hospital School Board of Directors to request a reduction in student nursing personnel and a concomitant increase in graduate nurse staffs in hospitals where such moves would be economically efficient. Institutions intimidated by the potential economic strain of a new staffing system were urged to undertake cost analyses of the apprenticeship model.\textsuperscript{88} By 1932, while the Private Duty Section continued to advocate group and hourly nursing schemes, the weight of the suggested solutions to nursing unemployment shifted dramatically. For the remainder of the decade, issues of hospital employment dominated CNA proposals to improve the economic fortunes of Canadian nurses. Private health services received only limited attention.\textsuperscript{89}

The one proposal which did emerge out of Weir's recommendation, was health insurance and socialized medicine. For those provinces where compulsory health insurance was under consideration, the CNA instructed its representatives to the Provincial Joint Study Committee to bring forth the question of such insurance "with a view to impressing upon those bodies the
necessity of socializing nursing services, as recommended in the Weir Report." In 1934, the Private Duty Section recommended that the CNA set up its own committee to study health insurance and its possible effects on private duty nurses. As Miss Buhler explained to the Private Duty Section:

Health insurance...would decrease the uncertainty and worry of private duty nurses. Each nurse would be on a salary basis and would be graded and supervised as to work and earning power as public health and hospital nurses are graded at the present time. Those who did not wish to accept such conditions would be free lance nurses as at present [entitled] to carry on an independent practice.90

In general, however, the concept of socialized nursing was lost amid Weir's extensive discussion of nursing education. Even the title of his final report, Survey on Nursing Education in Canada, reflected Weir's preoccupation with the training process, rather than with the problems of those nurses already graduated.

For all the intense interest and enthusiasm it engendered, Weir's report produced very little in the way of substantive economic improvements for nurses. While his recommendations did indeed provide ammunition for superintendents of nursing schools where student numbers were reduced, very little else occurred in terms of economic improvement. In many ways, the onset of the depression of the 1930s relieved the CNA of the pressure to do anything concrete about unemployment. The villain for nurses
became the economy, rather than nurses' position in the health care structure _per se._ The day-to-day struggles of finding work in local economies was confronted more directly by local and provincial associations, such as the Winnipeg General Hospital Nurses' Alumnae Association, and the Manitoba Association of Graduate Nurses.

The very nature of alumnae groups demanded that if they wanted to maintain memberships, they had to gain support from graduates before they left their training. Under ideal conditions, alumnae associations hoped to earn large new memberships every year, so that successful bodies such as the WGHAA were perpetually reminded of the economic concerns initiates into the work world faced. Since its formation in 1904 the WGHAA's mandate had included overseeing employment issues of its members. One of the first responsibilities assumed by the Association was the creation of an employment registry for trained nurses. Until that time, nurses seeking work placed their names on lists maintained by pharmacists in local drug stores. Alumnae historians recalled that "no enquiries were made regarding their training and lists were printed and distributed of all who called themselves nurses." In 1904, the alumnae group worked with the YWCA and the local Trained Nurses' Association to establish a registry located first at the YWCA and then, after 1914, at the Nurses' Home on Langside. In 1921 registry functions were taken over by the provincial association which throughout the 1920s and 1930s brought together patients needing care and nurses seeking work.  

91
92
93
Active intervention in the distribution of employment took on new dimensions in 1931, when unemployment among private duty nurses prompted the alumnae association to establish a "Graduate Nurses Trust Fund". WGH graduates working in and around Winnipeg were asked to make monthly donations to a fund designed to create more work for their unemployed sisters. The $2402.85 collected in the first year of the fund's operation provided 587 days of group nursing work for seventy-four nurses.

In the majority of cases nurses have been put on group nursing for ten days at a time, two patients each with the same hours off duty and paid on the same basis as group nurses on the Hospital Staff. This gives each nurse $31.50 for ten days, laundry and meals provided by the Hospital. On several occasions nurses have been put on with our own graduates who were ill.

Pearl Brownell, private duty representative from the MARN to the CNA, was the WGHAA member in charge of the fund. During the second and third years of operation, the fund grew to $4487.95, and between 1933 and 1934 $1104.25 subsidized 357 days work for 42 practitioners. Recognizing the limited financial resources available for such aid, the alumnae association suggested that MARN "advise nurses from other areas that we have a surplus of nurses in Manitoba." In 1935, contributions decreased markedly to less than $400. By 1936 one WGH graduate had concluded that:

We must face with equanimity the fact that this situation abounds - there are hundreds of
experienced nurses needing work, and vast numbers of sick requiring expert care, but to bring the two together is the problem engaging the attention of hospitals and governments everywhere....We are unable to solve this problem. It must work itself out of this vicious circle of No Money, No Work; No Work, No Money.98

After four years the "emergency" measure of the alumnae association had run dry, and graduates of the WGH joined the pool of nurses across the province relying on the Manitoba Association of Registered Nurses to try to create and equitably distribute employment.99

At the heart of all provincial associations lay the Registry. As the nexus between the legislative/educational goals and economic/member services of provincial organizations, and between the policies of the CNA and the demands for active intervention on behalf of working nurses, the Registry served to differentiate qualified from unqualified nursing personnel, and to connect qualified nurses with those patients or doctors requiring skilled nursing assistance. The lists of nurses who possessed the necessary public school education, who had apprenticed for three full years at an approved hospital, and who achieved passing grades on provincial examination were maintained by the Registry's paid or volunteer Registrars. Nurses meeting the legislative standards, which varied according to provincial legislation and over time, and who paid the annual association fee, could rely on the Registrar to
distribute fairly calls for employment received from doctors, patients, or institutions.

In Manitoba, as in the other provinces, the important role the Registry played placed it at the centre of controversy over how the association could best serve the short and long term needs of nurses. MARN's Registry was established in 1921, when the WGHAA decided to terminate its employment services. Stella Pollexfen, WGH graduate employed as Social Service Nurse at the Winnipeg General, was charged with the responsibility of communicating to MARN the alumnae's support for a provincial Registry. In May 1921 a committee composed of representatives from MARN, the WGH, St. Boniface and Children's Hospital alumnae groups, plus Nursing Superintendents from those three institutions, Misericordia, Victoria, Portage la Prairle Municipal, Brandon General and Dauphin General Hospitals was established to administrate the new Central Directory. This Central Directory Committee provided Monthly and Annual Reports of Registry activities to the Executive, which retained power over Directory policy, approving staff working conditions, deciding on conditional utilization of Registry services, and arbitrating grievances. As the sub-group responsible for issues affecting private nursing, the Private Duty Section ensured that Directory activity met the needs of nurses in the private sector.

Legislative changes to the provincial Act in 1924 paved the way for a paid Registry staff, and in January 1925 Elizabeth
Carruthers assumed the position of Registrar. Carruthers, and her successor after 1930, Annie Starr, focussed their energies on the process of registration of nurses, recording successful candidates of the examination held annually at the University of Manitoba, collecting Registry dues, and ensuring that calls for nurses were filled by those members available for work. As the Directory expanded its services, so too did its staff grow. In 1929 and 1934 MARN sought Registry assistants with "stenographic qualifications" -- an easy task given the plethora of women who worked as secretaries before entering nursing. By 1935 the provincial body employed four full time staff, an Executive Secretary, Registrar, Day Assistant Registrar and Night Assistant, to guarantee the smooth operation of MARN's most important service.

Smooth operation was not easily achieved. During the first years of its operation MARN committees spent time and energy determining membership and member access to the Registry. Each legislative amendment redefining "Registered Nurse" status jeopardized those nurses who qualified for Directory privileges under previous legislation, but in most instances MARN officers met members' requests for flexibility. In February of 1924, the Board of Directors agreed that increased educational standards and the establishment of provincial examinations "rigidly enforced would render a great hardship on a few nurses who had been nursing for a long time" and assented to permitting those nurses who had been members of the Registry prior to 1917 use of the Directory without
writing provincial examinations. Four nurses for whom "it would render a hardship to take the examinations" paid an extra $2 to the Directory and continued to use its services. As well, those nurses practicing before 1923 were to be able to write registration exams provided they met the minimum educational qualification in place before the 1923 amendments. Graduates waiting for the annual exams were permitted to utilize the Directory until that time, as were graduates awaiting the "supplemental" examination period.

As the Registry became more established, less leniency was granted individual applicants. In 1927, a 1913 grad of the WGH who was not granted her RN certificate "by waiver", and a recent graduate of the St. Boniface Hospital, who had been denied a sitting of the RN examination because she did not possess a complete grade 9 education, were not permitted to utilize the Directory.\textsuperscript{105} Requests for waived registration continued, but petered out as older graduate nurses left the workforce permanently. Still, in 1931 Mrs. Laura Gilbert, graduate of 1903, Morden, was instructed that registration without examination was no longer granted "since the expiration of the waiver".\textsuperscript{106}

In general these efforts to establish a recognized minimum standard for trained nurses were successful. Between 1914 and 1934, 3044 graduate nurses were "recommended for membership" by the University of Manitoba. Of those, only 238 chose not to pay for registration with the provincial association, while another 223
joined MARN reciprocally, totalling 2929 Graduates who were members at one time in their career. This high percentage of Manitoba graduates who joined MARN initially was not matched by their continued membership through annual dues. In January 1930, the Board of MARN discussed the problem of nurses who were not registered or had "allowed their registration to lapse." Yet many of these lapsed members were still receiving employment calls from the Central Directory, and by August 1931 the Convenor of the Private Duty Section reported that: "nurses were carried on the Central Directory lists who were one and two years in arrears, and six months was almost universal." Such data was confirmed later that year when the registrar reported that out of 267 nurses listed on the Central Directory, 133 had not paid their Registry fees from anywhere from one month to 2 years. In 1932 proposals to change the fee from ten dollars annually, to $6, were replaced in 1933 by a successful resolution that Directory charges be $8, paid in two instalments in January and July, and that dues unpaid within fifteen days of each deadline would result in the Registrant's name being stroked off the list of active nurses, or else referred to the Unemployment Committee. Dissatisfaction with the Directory continued, prompting further reorganization of the Registry, and suggestions in 1935 that MARN give up the Registry all together, leaving its operation to an autonomous board. Finally, in March 1935 a resolution from the Central Directory Committee was carried for action by the MARN Board, that: "arrears of fees in question, January
1930 to July 1934 - be written off the books to Sept 29, 1936, of the Manitoba Nurses Central Directory. Throughout this process the "leniency" demonstrated by the Directory was directly related to the financial difficulties confronting more and more private duty members. Association representatives and members realized that winning improved working conditions was related to united action. Registrars, the "business managers" of nursing associations, shared with their counterparts in trade unions the dilemma of maintaining both rank and file membership and organizational solvency.

Establishing standard fees, hours and conditions of labour was important for the Registry as it represented the value of nurses' work while preventing nurses from undercutting each other to the detriment of all. As economic conditions declined, solutions to unemployment included eliminating competition, creating more work, and distributing evenly among the active workforce that work which did exist. Implementation of these solutions created conflict which played itself out within the parameters of the various committees.

For example, at the third quarterly meeting of 1930, the MARN Board discussed Mrs. Doyle's "most lucid and interesting account" of the Private Duty Section's proposal for a ten-hour day, and publicity in the local press regarding the "ten-hour scheme". WGH Night Supervisor Miss McGillvray "wished to know just at what hour of the day the private duty nurse in hospital wanted the hours off," and her
co-worker in WGH Social Service Department, Miss Pollexfen suggested that a card be posted in each private hospital room outlining the "fees, rules and regulations." In fine democratic form, the Board moved "that when the directory committee and the Legislative committee met with the member of the P.D. Section to discuss the new rule, the Press and Publication Committee should also be asked to be present to give the matter publicity."111

Like the implementation of reduced hours of labour, solutions to the unemployment of private duty nurses were hard to implement. Working together, MARN directors and superintendent's of the city's nursing schools -- often one and the same -- utilized seven strategies to improve the amount of work available for their graduates. These were 1) lobbying for more graduate nurses on hospital staffs as instructors, 2) limiting enrollment in larger hospitals and closing nursing schools in smaller hospitals, 3) eliminating the monthly stipend paid to students, 4) rotating unemployed graduate nurses through staff positions in hospitals, 5) financing post-graduate training in hospital specialty departments for unemployed nurses, 6) financing group nursing and hourly nursing plans for semi-private and private ward patients and 7) investigating other employment opportunities for trained nurses.112 Thus the same administrators who in the early 1920s were pressing for enlarged residence facilities to house more students, were in the 1930s arguing for the necessity of reducing class sizes.113 In all, MARN leaders endorsed the strategies of CNA representatives and
focussed on the elimination of apprenticeship staffing of hospitals as the key to the economic crisis of their profession.

Occasionally frustrated nurses did attempt more militant strategies to improve working conditions. One way nurses demonstrated dissatisfaction with specific workplace conditions was through strikes. This job action was almost always spontaneous and, prior to 1940, was not endorsed by nursing organizations. For example, in 1894 nurses from the Victoria General Hospital in Halifax threatened to resign en masse if the "new rule" and the suspension of a nurse who had resisted it were not revoked. The "new rule" compelled nurses to "perform very objectionable work with male patients," including supplying bed pans and urinals, bathing, administering enemas and suppositories, and performing "private dressings." Administrative regulations that effectively denied nurses adult status and again made a mockery of their claim to professionalism provoked similar action by nurses at the St. Boniface Hospital in 1901 and at New Westminster's Royal Columbian in 1919. Nurses at the Winnipeg General threatened similar action when in 1902 four graduate staff nurses were "discharged on what seemed to the students to be insufficient grounds." The signatures of Isabel Stewart and Ethel Johns were two of those attached to a written protest submitted by student nurses to the WGH board of directors. Johns and Stewart were called before the board and threatened with expulsion for insubordination.
The board did not follow through with its threat, and the two completed their training. Later Johns realized:

It did not occur to me at the time (although it has since) that the directors may have been a little afraid of us. This must have been the first time that they had encountered an organized protest made on behalf of a traditionally submissive group....suppose that organized protest had led to organized action -- what might have happened then? The directors knew only too well that if the student working force were to be withdrawn the hospital would be forced to close its doors.117

Like the WGH example, most student nurses stopped short of carrying out their job action. When they did withdraw their service, little support was received from nursing organizations. For instance, in 1928 student nurses at Guelph's General Hospital walked off the job. In such instances nursing organizations could not endorse the actions of student staffs which challenged the position and authority of their members in supervisory jobs, and thus the Canadian Nurse unenthusiastically reported the event through a contribution from a former hospital director.

The recent regrettable discord in the staff of one of the general hospitals in Ontario has attracted far more attention than it deserved, due chiefly to the unwarranted meddling of a sensation-seeking city press....Had not outside meddling and publicity fanned the embers into a fierce flame the sparks of trouble would in all probability soon have been quenched. I am confident that
the nurses have been badly advised, probably by well-meaning friends, and that in cooler moments they will regret sincerely having taken part in an organized and decidedly unprofessional walk-out.\textsuperscript{118}

No further mention of the incident was made within the national journal. Certainly the actions of the Guelph students did not have the same impact on nursing as did the nurses' strike in Comox, British Columbia ten years later. The walkout by graduate staff at Comox's St. Joseph's Hospital underscored the need for Fraudina Eaton's study of labour conditions in British Columbia's hospitals.\textsuperscript{119} However the "discord" at Guelph provided insight into two key elements of Canadian nursing which prevented the fracturing of nursing organizations during years of economic discontent. First, the internal mobility of the occupation, through the nursing hierarchy as students, among various sectors as graduates, and between home and hospital as private duty nurses, precluded rigid social relations. Thus the \textit{Canadian Nurse} commentator on the 1928 strike sympathized with the difficult situations faced by many superintendents and urged student nurses to remember "when she feels aggrieved at the superintendent: she may be a superintendent herself some day."\textsuperscript{120} Secondly, given the difficulties faced by the Canadian labour movement during the interwar decades limited support was available for a working-class reformulation of nursing identity and organization. The 1928 Guelph strike suggested that broader community support existed for the students' actions, but, even if union organizers were so inclined\textsuperscript{121}, in a decade of "labour
defeated unionization of the already organized nurses seemed fruitless. Annie Glaz's 1934 contribution to the WGH Journal suggested that private duty nurses needed more than charity to solve their problems. However, her efforts to transform MARN into a union failed. The possibility of unionization was not incidental to the efforts by nursing educators to endorse improved working conditions. Revitalization of Canadian labour in the 1930s indirectly aided private duty nurses in their fight for shorter hours. As one CNA representative reminded the General Assembly, if the "Nursing Profession" could not establish improved working conditions "then it can be expected that labour groups will compel action by legislation."

New organizational forms did emerge, but not until the structure and content of nursing work, and the fortunes of labour organizing, changed in the 1940s. The introduction into the hospital workforce of large numbers of subsidiary patient-care personnel redefined nurses' position in the institution; most became part of but one of several groups of workers responsible for direct patient care, while a minority assumed administrative and supervisory position vis a vis other nursing and non-nursing staff alike. This fragmentation of patient services and fixed differentiation within nursing ranks led first to collective bargaining activities by "professional" associations and then to the creation in the 1970s of autonomous nursing unions. Until this point, only occasionally did rank and file nurses abandon their traditional organizational
structures. The example of nurses at the Vancouver General Hospital is instructive here. As early as 1942, mass meetings were being held in the VGH auditorium to organize hospital workers. Some members of the nursing staff attended these meetings, and shortly after the Hospital Employees' Federal Union (HEFU, now the HEU) was formed the VGH Graduate nurses joined Local 180 and in 1947 negotiated their first contract.¹²⁵ This cleavage between unionized staff nurses and supervisory nurses in management signified the end of the apprenticeship system.

I remember having this mass meeting and Miss Fairley being so upset that her nurses would feel they had to form a union to get things they wanted. She thought she had slipped, that her nurses had formed a union.¹²⁶

Fairley's plight represented the larger transformation occurring within her vocation. Differences between administrative and rank-and-file nurses, and among generations, which had been reconciled throughout the third generation of nurses began to crystallize within the fourth. While the local did not last, it did signal the future. Soon after World War II, the RNABC assumed collective bargaining responsibilities for its members, and "raided" the HEU. It was not until the 1970s that BC nurses created a union specifically for negotiating workplace issues, and even then the organizational form was premised on a trade-union model, rather than the industrial union format offered by the HEU.¹²⁷
It is important to understand that in spite of the transformation of the occupation, and the emergence of unionization as an organizational strategy, the earlier forms of collective action did not disappear. The groups which had been created in the earlier era continued to represent certain elements of the occupation, while maintaining their legislative and educational thrust. Most importantly, alumnae associations and the provincial organizations embodied the traditions and history of nurses' "small p" professional dedication to an essential human service.

The argument put forward by Wayne Roberts, among others, that occupational mobility and workplace fragmentation experienced by Canadian working women prohibited their collective activity does not hold true for nurses. Nor should the historiographical emphasis on the legislative struggles of early nurses' organizations lead to the conclusion that all nurses were or aspired to be "Professional". The varied class background of rank and file nurses, the gendered hegemony and mobility within the apprenticeship system of hospital training and staffing, the gendered dichotomy of health service provision and the uncertain, exploitative private duty market combined to establish a strong occupational identity as nurses and as working women. This identity was manifest on the shop floor, and within the particular organizational forms nurses created. Operating within a strong tradition of autonomous associational activity, first and second generation Canadian nurses developed five
levels of corporate structures which served to introduce new graduates to older nurses and to the political realm. With strong ties to other local and international nursing and feminist organizations, Canadian nursing associations had, by the 1920s, gained some measure of legislative success. The economic crisis of the interwar decades shifted their focus from political to economic issues, and threatened to dissolve corporate unity. While nursing organizations successfully resisted that threat they did so on terrain defined by nursing educators. Hospital employment improved the financial stability of rank and file nurses, but could not provide the conditions of work which had made private duty care so popular. The struggle between the professional vision of nursing educators and the workplace demands of private nurses was resolved within corporate vehicles which by tradition and function were rooted in nurses' unique occupational identity as skilled service workers. The fact that nursing associations did not conform to the organizational structure of their male counterparts reflected the fact that the experiences of these working women demanded a different, if not always cohesive, collective voice.
Notes


2 For the story of the international body, see D.C. Bridges, History of the ICN, 1899-1964 (London: Pitman Medical Publishing Co. Ltd.). Initially, ICN Congresses were held every five years, then triennially and in the 1920s and 1930s, quadrennially.

3 Margaret M. Street, Watch-fires on the Mountains: The Life and Writings of Ethel Johns (Toronto: University of Toronto Press, 1973), p. 42.

4 Histories of nursing emphasized the important interconnections between nurses and feminists. For example, Dorothy Riddell, "Nursing and the law: The history of nursing in Ontario" in Mary Quayle Innis, ed., Nursing Education in a Changing Society (Toronto: University of Toronto Press, 1970), p. 20.

5 While communication with American nurses predominated important interaction with British and European representatives also occurred.

6 B. Melosh, The Physician's Hand: Work Culture and Conflict in American Nursing (Philadelphia: Temple University Press, 1982). Melosh discusses the various national organizations which competed for nurses' membership and loyalty, as well as the three national journals which spoke for and to nurses. In Canada, no competing organizations emerged until after 1945, and then permanently after 1970.

7 Johns recognized this in 1930 when she reported "Canadian nurses now form a well integrated national group. Foreign observers have frequently commented on the remarkable fact that in a thinly
populated country, extending over such vast areas, it has yet been possible for Canadian nurses to develop a national consciousness which united expression in such a heavy undertaking as the International Congress in Montreal." Ethel Johns, "The Biennial Meeting Canadian Nurses Association," Canadian Nurse 26 (August 1930): p. 396. Official histories published by the CNA and the provincial associations stressed the efforts of nursing leaders to overcome differences among Canadian nurses. For example, the history of nursing organizations in Quebec documenting the resolution of conflicts between the French and English-speaking nursing organizations there is titled An Experiment in Mutual Understanding.

8 Canadian Nurse section "newsnotes" was particularly useful for this purpose. For example, see Canadian Nurse, 26 (May 1930): pp. 145-46.

9 A small contingent of male nurses did practice during the first half of this century, but to date I have discovered no evidence of men participating in any of the associations.

10 Even a brief reading of the CNA "Official Directory", published monthly in the Canadian Nurse, reveals this trend. In 1928, 1930, and 1932 for example, the Executive Committee of the Canadian Nurses Association all listed hospitals or government offices as their mailing addresses. Provincial representatives from Manitoba tended to be split, with long-time nursing personalities such as Miss Jean Houston of the Manitoba Sanatorium in Ninette, and Miss Mildred Reid of the WGH joining three other representatives from the province at the biennial convention. At the provincial and alumnae level, where geographic proximity might have facilitated more extensive private duty participation, the presence of hospital personnel was even greater. In 1930, the Manitoba Association listed Miss Houston, Miss Reid, Miss Christina Macleod of Brandon General, Miss Robertson of the Municipal Hospital, Miss Norah O'Shaughnessy and Miss A.E. Wells of the Provincial Health
Department, and Miss LaPorte of the Misericordia Hospital, all as members of the executive. The remaining four positions were filled by women whose addresses did not suggest administrative postings. "Official Directory," Canadian Nurse 28 (December 1932): pp. 677-78.

11 Julia Stewart's "The Inception and Development of the Graduate Nurses Association, Ontario, 1904-1926," reviews this difficult process in Ontario, the last province to win nurses' legislation. Describing the bill presented to the Ontario House, Stewart wrote: "No serious opposition was met till the bill came up for its third reading when it was violently opposed by representatives from ten boards of some of the small hospitals, as well as some of the larger ones.... The public press assailed the measure as 'Trade Unionism' of the worst type, and members of the House heretofore friendly to it, became either indifferent or actively hostile. When the Committee of the House, which had the matter in hand, made its final report, the bill had been altered to such an extent as to nullify what the organization had in view." For further discussion of medical and political opposition to nursing legislation see Joanne Whittaker, "The Search for Legitimacy: Nurses' Registration in British Columbia, 1913-1935," in Barbara K. Latham and Roberta J. Pazdros, eds., Not Just Pin Money: Selected Essays on the History of Women's Work in British Columbia (Victoria: Camosun College, Publishers, 1984); McPherson "Nurses and Nursing in Early Twentieth Century Halifax, 1900-1925," (M.A. thesis, Dalhousie University, 1982).

12 Organizations continued to press for legislative changes which would grant increased legal authority over their members and over competition. In general however, these early struggles are celebrated within the nursing literature both because of the intensity of the campaigns, and because of the need to reinforce commitment to "professionalism" which such tales instruct. For a discussion of the professional histories of nursing organizations see Chapter 2.
13 For a discussion of the use of the term proletarianization with respect to nursing see Chapter 1.


18 Canadian Nurses' Association, 1928, pp. 11-12, (National Archives).


21 Riddell, "Nursing and the Law," p. 19. Canadian women called this group the "Society for Superintendents of Training Schools in United States and Canada."

22 CNA, Minutes, 1924.

23 CNA, "Nursing Education Section, Chairman's Report," Minutes, 1926, p. 56.

24 Each section followed a constitutional model, electing an executive and following published by-laws. For example, the revised
Private Duty Section By-laws were appended to the CNA, Minutes, 1936.


26 The *Canadian Nurse* became the property of the CNATN in 1916, when Miss Helen Randal was named national editor. Stewart, "The Inception and Development of the Graduate Nurses Association, Ontario 1904-1926," p. 67.

27 For example in 1926, reports from the Federated Associations included one from the Manitoba Association of Graduate Nurses read by Miss E. Russell, that of the Brandon Graduate Nurses Association presented by Mrs. Darrach, and Mrs. McLeod's report from the St. Boniface Hospital Alumnae Association. CNA, Minutes, 1926, p. 41.

28 CNA, Minutes, 1928, pp. 4-5.

29 CNA, "Report of the Committee on Dual Membership," Minutes, 1932, pp. 3-4.

30 Other dissent may have existed, but only the WGHAA went on record as such. The Winnipeg nurses' willingness "to co-operate in carrying out the decision of the meeting" led the CNA to claim unanimous support for the move. No indication was given as to the opinion of the Children's Hospital Alumnae Association which had only gained CNA affiliate status in 1926, or of the St. Boniface, or Brandon Alumnae groups. CNA, Minutes, 1926, p. 39. CNA, "Report of the Committee on Dual Membership," pp. 3-4.

31 See McPherson, "Nurses and Nursing in Early Twentieth Century Halifax" for a discussion of the relative strengths of the Nova Scotia association and the Victoria General Hospital Alumnae group.

Conference, Victoria, B.C., 1986 for a discussion of the activities of the Vancouver General Hospital Alumnae Association; see also, Ethel Johns, The Winnipeg General Hospital School of Nursing, 1887-1953 (Winnipeg, 1953).

33 Quoted in Street, Watchfires on the Mountains, p. 2.

34 When in 1905, the St. Boniface Hospital graduates established their alumnae association the superintendent of the school was named honorary president. "History of St. Boniface School of Nursing," n.d. (St. Boniface, Man: St. Boniface School of Nursing Archives, n.d.).

35 VGHAA, Minutes, 1932, (VGHAA Archives).


37 Viola Erickson, Lecture Notes, (WGHAA Archives).

38 For example the Department of Student Nurses of the April 1926 Canadian Nurse published WGH student Isabella Craig's description of her days at Winnipeg's visiting nurse agency, "Around the City with the Margaret Scott Nursing Mission."


41 The St. Boniface General Hospital stopped printing student yearbooks during the 1930s. Larger institutions such as the Winnipeg General continued to create their version, the Blue and White, throughout the interwar years. (WGHAA Archives). See also VGH Student Council, Annual, 1920-1940, (VGHAA Archives).

43 Anne Ross, interview by author, Tape recording, Winnipeg, Manitoba, 4 August 1988.

44 See Figure 6.1; Canadian Nurses Association, A Brief History of the Canadian Nurses Association founded in 1908.


46 Florence Paulson, interview by author, Tape recording, Winnipeg, Manitoba, 1 July 1987.


48 Ibid, p. 5.

49 Edouard Desjardins, Heritage: History of the Nursing Profession in Quebec from the Augustinians and Jeanne Mance to Medicare (The Association of Nurses of the Province of Quebec, 1971).

50 Canadian Nurse (April 1917): pp. 210-11. When suffrage was achieved, the April 1919 GNANS proudly reported to their sisters across the Dominion that 7000 women had entered their eligibility for voting at City Hall. Canadian Nurse (April 1919): pp. 1704-5.

51 MARN, Quarterly Meeting, Minutes, September 1935.

52 MARN, Minutes, April 18, 1933.

53 Canadian Nurse (July 1917); Ibid (April 1924).

54 Julia Stewart, "The Inception and Development of the Graduate Nurses Association, Ontario 1904-1926," p. 65 states that "The first work undertaken by this committee was preparation of a paper on "Registration" which was read at the annual meeting of the National Council of Women, held in Charlottetown, PEI in June 1905. It was
felt that this would be an educative measure and serve to acquaint the body of influential women with the object in view, and would enlist their sympathy and help in obtaining the desired legislation."


56 For a discussion of the parallel careers of WGH's two most illustrious graduates, see Chapter 2.


58 In 1927 MAGN gained control over graduates of eighteen-month training programs in mental, contagious and obstetrical hospitals. MARN "Registration Act, Constitution and By-Laws" 1927. (MARN Library).

59 MARN's 1935 "Registration Act, Constitution and By-Laws," first assented to on February 15, 1913 and amended in 1920, 1923, 1927, 1929 and 1935, determined that "Every person registered under this Act shall be known as a registered nurse, and any person not being registered under this Act assuming such title, or using the abbreviation "Reg.N." or in any manner representing that he or she is a registered nurse, or by false or fraudulent declaration attempting to procure registration under this Act, shall be liable...to a fine of twenty-five dollars, and in default of payment to imprisonment for a period not exceeding six months." pp. 9-10.


61 Canadian Nurse 3 (March 1921): pp. 159-60

62 Ibid.


65 Randal adhered to her belief that anonymity was the "only way to promote free discussion in the Canadian Nurse," and to her opinion that the anonymous letter was not a personal attack on Johns. Johns considered the letter an "unprovoked attack." The General Assembly passed by 66 votes a resolution in favour of continuing the editorial policy of permitting the publication of anonymous letters provided the editor possessed the author's name and address. "Report of the CNATN Convention, Quebec, June 1921," *Canadian Nurse* 7 (July 1921): pp. 416-17, pp. 433-34.


67 Ibid.


69 Ibid.

70 Seven provincial representatives read their reports, while reports from Saskatchewan and Alberta were not sent due to the postal strike. CNA, *Minutes*, 1924.


73 Gunn served as Secretary of the CNA 1914-1917 and President 1917-1920, and was elected second Vice-President of the ICN in 1925. A 1905 graduate of New York's Presbyterian Hospital, Gunn assumed the helm of the TGH in 1913. "International Congress of Nurses," *Canadian Nurse*, (March 1929): p. 119.
74 CNA Minutes, 1924, pp. 17-18.

75 Ibid.

76 Ibid.

77 Ibid.

78 CNA, "Private Duty Section," Minutes, 1926, pp. 52, 63.


81 CNA, Minutes, p. 16. The Private Duty Recommendation is on page 14.

82 CNA, "Private Duty Section", Minutes, 1934, p. 43. A paper by Miss Mirfield on "Eight Hour Duty as Initiated in British Columbia" sparked discussion concerning "hours of duty, number of meals, payment of same, and recreation for the nurse."

83 CNA, Minutes, 1938.

84 Canadian Nurse (1921).

85 CNA, Minutes, 1926, p. 64.

86 CNA, "Private Duty Section", Minutes, 1928, p. 41.

87 CNA, "Nursing Education Section," Minutes, 1930, p. 16.

88 CNA, Minutes, 1932.
89 CNA, Minutes, 1934, 1936, 1938, 1940.

90 CNA, "Private Duty Section," Minutes, 1934, p. 43.

91 For example, Violet McMillan was one of the few WGH graduates interviewed who had so little work in the 1930s that she applied for and received relief vouchers from the municipal government, but because "no one had any money" she did not credit her impoverishment to her occupation per se. Violet McMillan, interview by author, Tape recording, 23 June, 1987, (PAM).


93 Ibid, p. 44. WGHAA, Journal (June 1921), (July 1920), p. 15 lists the fee scale established by the WGH Registry.


99 Anne Glaz, "We Accept the Challenge," Journal (1934): p. 19. A Grad of 1934, Glaz wrote "As for alumnae assistance, it is only a relief measure which is temporary and cannot exist very long."

100 MARN Executive Meeting, Minutes, May 9, 1921.

101 For example on June 5, 1930 "the question of the summer holiday, and summer replacement" was brought forward and discussed by the Board. On June 10, 1931, a similar discussion took
place, MARN, Board of Directors, Minutes, June 5, 1930 and June 10, 1931.

102 MARN, Minutes, April 14, 1925, addresses the duties of the Registrar "for matters pertaining to registration of nurses."

103 MARN, Minutes, Nov 22, 1929; also July 23, 1934.

104 MARN, Minutes, July 23, 1934. At this special meeting of the MARN, 33 members considered the expansion of the Directory staff, and were told that prior to the appointment of the Registrar "there was no one in charge of the office of the MARN, the Executive Secretary being on a part time basis only."

105 MARN, Minutes, July 11, 1927.

106 MARN, Board of Directors, Minutes, August 7, 1931.

107 MARN, Board of Directors, Minutes, January 30, 1931.

108 MARN Board of Directors, Minutes, August 7, 1931.

109 MARN Board of Directors, Minutes, November 6, 1931. In December of that year the Board again discussed "the matter of a number of nurses on the Central Directory who are getting a good deal of work, and who [sic] fees remain unpaid over a period of a year, etc.,...those who could pay do so, and this committee should look into the matter."

110 MARN General Meeting, Minutes, 1935.

111 MARN General Meeting, Minutes, 1930.

112 MARN, Board of Managers/Directors, Minutes, 1919-1940; MARN, Annual and Quarterly Meeting, Minutes, 1920-1940.

113 Barbara Melosh differentiates between the educational leaders seeking improved educational facilities for fewer women in American training schools, and the older generation of
superintendents committed to the traditional apprenticeship system of staffing. In Canada, such a differentiation did not emerge, in part because of the smaller group of women involved and in part because of the cohesive nature of Canadian health care generally. Melosh, *The Physician's Hand*, chapter 2.

114 "The Nurse will be Reinstated," Halifax *Herald*, 28 December 1894, p. 8b. Thanks to Judith Fingard for contributing this example from her research.

115 On July 27, 1901, 15 nurses there walked out "owing to objectionable regulations requiring them to be in by 7:30 each evening and to be escorted to church by male escorts." *The Daily Colonist*, Victoria B.C. 28 July 1901. Thanks to Doug Cruikshank for contributing this piece of research.


117 Ibid.


123 Annie Glaz, "We Accept the Challenge,"; Anne Ross, Tape recording.


126 Harriet Pentland, Tape recording.

127 Dent, "Beginnings"; Irene Goldstone, "The Origins and Development of Collective Bargaining by Nurses in British Columbia".

Chapter 7
Conclusions
"The price of generations..."¹

In the spring of 1989, as I was writing the final draft of my doctoral dissertation, an examination of the third generation of Canadian nurses, the current generation were themselves writing a new chapter in the history of Canadian nursing. Frustrated with inadequate staffing, intensified pace of work, insufficient salaries, and dramatic outmigration of their co-workers from the province and the occupation, nurses in British Columbia went on strike. On June 14, when negotiations between the British Columbia Nurses Union's (BCNU) and the Health and Labour Relations Association (HLRA) broke down, nurses took action, shutting down all but essential services of the health care delivery system.² Allied workers in the Hospital Employees Union (HEU) soon joined the walkout.³ Within two weeks the HLRA had proposed a contract, offering 29.5% wage increase over three years, which the BCNU bargaining committee tentatively accepted.⁴

Such strike action was not unprecedented, for in recent years growing militancy among Canadian nurses had been manifest in a bitter strike in Alberta and a prolonged work-to-rule in Quebec.⁵ However, events in British Columbia took a radical turn when dissident union members challenged their own bargaining committee and mounted a determined campaign to convince nurses to reject the proposed contract. Between June 26 and July 12 leaders of the
dissident group, Vancouver General Hospital's (VGH) Bernadette Stringer and Debra McPherson, drove 1600 kilometres meeting with nurses throughout the province and arguing that the contract would not solve nurses' problems. Their efforts paid off. On July 12 65% of BCNU members - including 85% of VGH staff - supported McPherson and Stringer's "vote no" campaign and rejected the HLRA offer.

The rationale for dissent was clear. BCNU members believed that greater financial incentives -- greater than even the 29.5% -- were necessary to attract and keep enough new nurses to reduce the overwork, stress, and "burn out" debilitating the existing workforce. Over 2000 additional nurses were required if BC health care workers were to provide adequate patient care, but many RN's agreed with student nurse Marcia Weir's sentiments, "I want to stay and work in BC when I graduate, but I will not stay where I am taken for granted". Only drastic measures would protect and defend the interests of patients and practitioners in BC's health care system. As primary care-givers responsible for patients' health, nurses believed that the long-term goals of quality service demanded a withdrawal of that service in the short term. In the words of BCNU president Pat Savage: "ethically [nurses] see themselves as patient advocates and are obliged to speak out." Even Savage herself, sensitized to the militancy of her membership, did not anticipate that nurses' commitment to quality care would lead them to speak
out both against employers and, if necessary, against their own union leadership.

For some nurses, their experiences in other provinces convinced them of the necessity to persevere until a satisfactory settlement was won. VGH nurse Cheryl Davis, veteran of 1988's nineteen-day strike in Alberta declared: "I think we should have stayed out longer [in Alberta]" and encouraged her peers in B.C. to stand firm stating, "we have to suffer now but I think in the long run it will be to our benefit." In British Columbia as elsewhere, striking did not come easily to most nurses. Operating room nurse Brenda Kormin articulated the ambivalent feelings that withdrawal of service evoked in many nurses.

I support the strike all the way. But I was born in this hospital. So were my two kids. We have to take this action but it's the complete opposite of everything we do, everything we trained for.\(^9\)

That nurses like Kormin would take so militant a stand signified the extent of their frustration as well as a more fundamental transformation occurring in nurses' collective consciousness. Two factors informed that transformation. The first was the feminist critique of society's devaluation of women's work.\(^11\) The second was the increasing presence of female service workers within the union movement.\(^12\) Together these social forces prompted nurses to question the concepts of femininity and professionalism which had
been central to their occupational identity and organizational form.¹³

For many, answers lay in the history and traditions created by their predecessors. Debbie Oliver, nurse and daughter of a nurse, explained:

I think about leaving the profession but it is part of my soul, my very being. As my mother before, I will always be a nurse. My spirit was broken long ago but every once in a while, I feel the old enthusiasm coming back. Lately, those feelings are harder to hold onto...¹⁴

Looking back over her mother's career Oliver concluded that "this nursing crisis has been with us for many years" and that only when public recognition was won for the "bedside nurse...the most important care-giver in the system" would solutions be found. For this sixteen-year veteran of the Canadian health care system, the British Columbia strike alone would not resolve nursing's problems.

I don't know that the answer will be, but for a brief moment in Canadian history, we felt we were important.¹⁵

Such commentary reveals that the contemporary crisis has revitalized nurses' interest and awareness of their place in Canadian history and has raised new questions about the persistent difficulty nurses have experienced in winning social value and economic reward for their work. Clearly, the portrait of progress depicted in conventional nursing history does not speak to the emerging
frustration and disillusionment being manifest through strikes and walkouts. Thus as they cast their vision backwards the fifth generation of Canadian nurses are beginning to reassess the meaning of caring, present and past.

This thesis contributes to that re-evaluation by focussing on another period of economic crisis, 1920-1939, and the generation of nurses working through it. This examination of the structure and content of nursing work during the interwar decades begins by suggesting a chronology of Canadian nursing from the inception of formal training in the 1870s through to the present. It argues that significant changes have distinguished the experiences of nurses over the past century, and that the concept of generation captures the differences between generations, in particular the unique socio-economic conditions in which the third generation worked. However, the concept is also a useful tool for examining the interaction among generations, and the important role older nurses played in initiating new practitioners into the occupation. The periodization presented in Chapter 1 asserts that five generations of trained nurses have plied their trade in Canada, within two distinct models of health services. While further refinement of the precise divisions between certain generations remains to be done, such a chronological framework is essential in recognizing that nursing care is neither biological, nor universal, but specific to time and place.
Within this broader chronological framework, this study of Canadian nursing reveals that the interwar decades were years of crisis for Canadian nursing, during which the transition from the older health care system of private and predominantly domestic care to the modern institutional system of socialized medicine began. The crisis which beset Canadian nursing in the 1920s and 1930s was the product of a system of hospital staffing which depended upon student labour, and which adjusted the student workforce to meet changing demand for hospital services. Thus the size of the graduate nurse population was increased by the very force which was simultaneously decreasing the demand for private nursing care. Superintendents of nursing schools and associational leaders -- often the same women -- represented an older generation of trained nurses. These veterans of the campaigns to organize nurses, to achieve nursing legislation, and to win female suffrage had also trained the new generation graduating from hospital schools in the interwar years. Yet this third generation confronted a very different set of workplace issues, defined by economic, rather than political, barriers. For many working nurses the solution to unemployment and low wages was migration, from their region or their occupation. Those who stayed struggled with the contradiction of service; to demand value for their labour meant withdrawal of service, and yet refusing to work called into question their dedication to service.

The people who faced this crisis were defined by gender and were recruited from the female labour market. Those women were
predominantly single, native-born, and white, and as a group boasted
slightly greater ages and education than most women workers.
These sociological advantages were not class-bound, as women from
all social class backgrounds pursued nursing careers. Hospital
schools of nursing recruited from an elite segment of the sex-
segmented labour market. The collective portrait of the Canadian
nurses drawn from national and local sources supports the
theoretical assertions regarding the importance of labour market
segmentation, but extends that analysis to include the existence of
further differentiation within that labour market.

Being a woman was a necessary criteria for being a nurse. But
being a woman was not the only criteria. The availability of a pool
of educated women from which hospital schools of nursing could
draw was conditioned by the attitudes of women seeking work. The
reality of limited occupational choices, and of the inferior pay and
status of many "women's" jobs, made women conscious of the
importance of skilled training and accreditation. While this was
true for urban women, it was most acutely felt by rural inhabitants.
Nursing provided the daughters of the countryside with a respectable
route to job skills and the urban job market.

Once at the workplace nurses encountered social relations
structured by gender and class. The nursing hierarchy, which
determined nurses' status as they traveled through it first as
probationers, then juniors, intermediates and seniors, reinforced
nurses' subordination to doctors while establishing fluid relations among nurses. Students deferred to all their nursing superiors, knowing they would soon themselves occupy that position. Upon graduation, most nurses engaged in private duty work which not only offered independence, variety and some choice, but also removed nurses from direct supervision by other women. Even as specials within hospitals, graduate nurses deferred to particular superiors only during that case. Thus the relations of dominance and subordination characterizing student and staff relations within hospital training programs did not define a permanent set of relations between hospital superintendents and rank-and-file nurses in the private market.

As fixed, hierarchical relations did not divide nurses during this period, the content of nursing work served to strengthen nurses occupational identity. Within hospital training programs the limits and rituals of nursing practice were established as students practiced and perfected the many routines which constituted their technique. Nursing technique was predicated upon a practical application of the germ theory of disease causation: good technique demanded careful maintenance of a germ-free environment through antiseptic and aseptic practices. Two sets of conclusions are worth repeating here. First, as well as the many therapeutic and administrative responsibilities assumed by nurses, the numerical importance of nurses to Canadian hospitals suggest that nurses deserve a more substantial place in the history of health services
than the social history of medicine has warranted to date. What nurses did mattered -- mattered to the hospital, to doctors and to the patients -- and thus nurses were key elements in the the social relations at the bedside. This thesis argues that nurses were particularly important during the interwar years when the crisis within the occupation prompted nurses to promote changes affecting the entire health care system. Thus, as the social history of medicine seeks to broaden its critical framework, it must find a place for the medical workforce which dominated patient care in the pre-1940 decades.

Secondly, the wide range of therapeutic, administrative and personal tasks for which nurses were responsible were broken down into their component parts and learned as routinized rituals over which nurses had little control. Patriarchal relations between men and women reinforced the division of labour and authority within the health care hierarchy. The increases since the late nineteenth century in the absolute number of tasks nurses have performed have not affected the power of the medical profession to delegate patient care functions. On these terms, nursing practice can be characterized as desskilled. However, nurses themselves defined their skill not only in terms of the execution of medical directives, but rather in terms of a system of practice which integrated curative functions with personal care. The structure and content of nurses' work differentiated them from doctors, but also distinguished nurses from "unskilled" attendants in the community.
These were not just any women. They were nurses, skilled medical assistants whose jobs, as represented in their uniforms, legitimated their presence in the public sphere, day or night. For Canada's third generation of trained nurses, their difficulty claiming skilled status in the workplace was rooted in their inability to claim remuneration for their services, rather than in the content of their practice.

What does this examination of the structure and content of nurses' work reveal about the nature of nurses' consciousness and self-perception? As the analysis of nurses' associational structures and activities demonstrated, conflict within Canadian nursing organizations developed during the 1920s and 1930s. Nursing's majority, working in private duty and represented by the private duty sections, demanded collective solutions to deteriorating working conditions. The emphasis on professional development which characterizes most Canadian nursing history masks the importance of internal dissent and workplace issues in determining associational issues. Is, then, "work culture" a more useful concept than that of professionalism to characterize nurses' consciousness? Nurses in Winnipeg and elsewhere did use individual and collective forms of action to defend their own definition of good nursing. But the importance of the occupation to non-practicing nurses signified an element of nursing not encompassed by the concept of work culture. Nursing was appreciated by women not only for the value they placed on the actual work, but also for what the occupation represented. For while many nurses actively practiced for only a
short time, nursing promised the potential for economic independence should marriage fail. Given the limited economic opportunities for women, nurses defined their skills in terms of relations at the workplace and also in terms of the disadvantage they faced in society at large. Work culture alone does not capture the possibility of choice that nursing implied for Canadian women.

As well, work culture is a somewhat vague label for an occupation with such clearly defined organizational structures. MacKay's critique of the imprecision of the term seems particularly appropriate when considering the formal nature of nursing's collective action. Associations at the local, provincial, national and international levels provided Canadian nurses with forums to promote their interests and, while divisions among nurses were important causal forces in how those organizations acted during the interwar years, nurses made conscious efforts to maintain the unity which economic crisis threatened to dissolve. The concept of culture obscures the strong occupational identity which inspired these organizations. And finally, implicit in the concept of work culture is nurses' affiliation with other workers. Certainly nurses shared with unionized workers the same struggles of wages and working conditions. But nurses did not ally with working class representatives in any consistent way, nor did they define themselves as working class. The third generation of Canadian nurses borrowed from the strategies of professionalism, and
unionism, but neither model was satisfactory in resolving workplace problems, or reflecting their occupational identity.

Out of the structure, content and traditions of their work, nurses created and sustained an occupational identity, manifested in their organizations, which defined nurses as professionals, skilled workers, female care-givers to be sure, but women possessing specific scientific technique. Through their occupational identity nurses tried to resist alienation from their work -- to resist the dichotomies between object and subject, practitioner and patient, worker and product, curing and caring which were inherent in the industrial-capitalist economic structure. For the third generation of Canadian nurses, gender and class operated together to create a unique occupational identity which blended professional dedication to service, workplace pride in skilled caring, and personal confidence in the potential for economic self-sufficiency.

As events in British Columbia, 1989, demonstrated, subsequent generations of nurses, facing a very different structure and content of their work, would recast this occupational identity. And yet the traditions established by nurses earlier in the century, and passed over time from one generation to another, remained a powerful force inspiring occupational pride but also divisions among nurses which have proved difficult to resolve. It is a testament to the strength and tenacity of the associations which represented third generation nurses, that, in the modern era of nursing unionization and militant
strike activity, those organizations, created nearly a century ago, continue to flourish. Perhaps one of the most important functions served by bodies such as the WGH Alumnae Association is the preservation of historical sources, documenting the often unappreciated historical contributions of previous generations of Canadian nurses.

The Winnipeg General Hospital School of Nursing Alumnae Association archival collection is stored and displayed in a small room in the "new" School of Nursing building. Constructed in 1956, the building is part of the Health Sciences Centre, a sprawling mass of buildings erected on the original Bannatyne and McDermott location which over the past 30 years has engulfed and largely smothered the original WGH structure. To reach the Alumnae Association Archival Room the dedicated researcher must travel down the long hall which runs the length of the School of Nursing building. The narrow hall is lined with office doors, and half way down the hall jogs left then right and continues onto the far end of the school. At that zigzag a door marked "Alumnae Centre Archival Room" leads into the space designated for the use of the Alumnae Association. The door itself would cause no comment were it not for the fact that it is copper, salvaged off the front entrance of the "old" nurses residence before that building's demolition. During the fifty years of its existence, student nurses hurried through that copper door in order to meet curfew, or else had to take their chances climbing up the fire escape to their rooms, or sneaking into the
residence through the underground "rabbit run", from the hospital to their home. The copper door now serves a less-severe function, provoking curiosity rather than panic for the young women passing by, for few in the school of nursing building know what exactly lies beyond it. The treasures stored within are as foreign to the current generation of graduate nurses as is the world those treasures represent.

When I first visited the Archival Room in 1986 I was struck by the juxtaposition of functional design and feminine decor. The standard elements of modern architecture -- wooden cupboards with sliding doors lining two walls, fluorescent lights running the length of the ceiling, the floor tiled and a large emergency exit at the far end -- were somewhat masked by the Alumnae possessions. In the front half of the room two sofas, a few armchairs and several polished-wood end tables were set on a large Persian rug ready for a small meeting followed by tea. In the back part of the room, two large tables served as work space, next to which in a large glass-fronted cabinet stood two mannequins. One was dressed in the military uniform worn by WGH graduate Alfreda Attrill during her years in the Canadian nursing services of World War I. Her partner sported a very different garb -- the doctoral gown of Isabel Maitland Stewart. A smaller, glass-topped chest displayed other memorabilia. The tools of nurses' work -- syringes, scissors, hot water bottles and bedpans -- lay next to medals of proficiency and military decorations awarded WGH students, class pins, the gold
locket presented to Isabel Stewart by the Alumnae Association, a medicine chest complete with labeled glass medicine jars, and last but not least, the typewriter of 1902 graduate Ethel Johns. Each memento was labeled to catch the interest of Alumnae members visiting the centre.

Over the past three years the room has changed somewhat. Increased historical awareness and hard work on the part of Alumnae volunteers, prompted in part by the 100th Anniversary of the School of Nursing, resulted in the installation of large new display cabinets to replace the old wooden storage cupboards. Behind the glass doors of the new cabinets a new kind of historical symbol has gained prominence. Written sources such as student notebooks, yearbooks, and journals have won greater appreciation and recognition, inspiring further efforts by volunteer archivists to acquire personal collections from aging members and to develop improved facilities for storing and displaying those collections. Throughout this process the traditional collection of material sources remains. Uniforms, syringes, a gold locket and a typewriter together represent the symbols of skilled, articulate and self-conscious generations of women workers. Like the Archival room itself, nurses have imposed on the modern workplace their identity as women and as workers. And yet, like that repository, nurses' experiences and contributions have too often been isolated and ignored. Beyond the copper door lies a rich and vibrant history, which can reveal to the current generation of nurses, as well as to
historians probing the development of health services and nursing's role in it, the meaning and contradictions of caring, and the legacy of skilled service, which have constituted nursing's past.
1 June Callwood, "Suspicion leaves its scars" Globe and Mail (National Edition) January 18, 1985. In the wake of the Grange Commission's investigation into deaths at Toronto's Hospital for Sick Children, journalist Callwood assessed the inquiry's devastating effect on nurses. She wrote "though the nurses are exhausted from more than three years of stress marked by long periods of fear and humiliation, they can already see that what happened to them was sitting in the medical system for a century, waiting to explode...The price of generations of conditioning is a profession marked by timidity."


11 For a critique of femininity and gender roles in nurses' work see Janet Muff, ed. Socialization, Sexism and Stereotyping: Women's Issues in Nursing (St. Louis: C.V. Mosby company, 1982).


15 Ibid.


17 The work of Archivist Elaine Trescoor has proven particularly valuable, not only in improving archival facilities but in encouraging projects such as that completed by Kathryn McPherson and the WGHAA, "Nurses and Their Work: Oral Histories of Nursing in Winnipeg, 1920-1929", Tape recordings, WGHAA Archives and PAM.
APPENDIX A

"Nurses and Their Work:
An Oral History of Winnipeg Nursing, 1919-1939"

BIOGRAPHICAL INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Education Dates</th>
<th>Date of Birth</th>
<th>Place of Birth/ &amp; Hometown*</th>
<th>Date of Retirement</th>
<th>Ever Married</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olive Irwin</td>
<td>11 1918-21</td>
<td>1896</td>
<td>Holland, Mb</td>
<td>1925</td>
<td>Y</td>
</tr>
<tr>
<td>Florence Paulson</td>
<td>10 1919-22</td>
<td>1898</td>
<td>Wpg /Gimli, Mb</td>
<td>1975</td>
<td>Y</td>
</tr>
<tr>
<td>Ingibjurg Cross</td>
<td>11 1921-24</td>
<td>1901</td>
<td>Ebor, Mb</td>
<td>1950</td>
<td>Y</td>
</tr>
<tr>
<td>Grace Parker</td>
<td>12(1) 1921-24</td>
<td>1899</td>
<td>Sanford/Wpg, Mb</td>
<td>1964</td>
<td>N</td>
</tr>
<tr>
<td>Mary Duncan</td>
<td>11 1923-26</td>
<td>1897</td>
<td>Glenlyon, Mb</td>
<td>1930</td>
<td>Y</td>
</tr>
<tr>
<td>Josephine Mann</td>
<td>11 1925-28</td>
<td>1906</td>
<td>Hillview, Mb</td>
<td>1976</td>
<td>Y</td>
</tr>
<tr>
<td>Mary Shepherd</td>
<td>11 1925-28</td>
<td>1908</td>
<td>Beulah/Wpg, Mb</td>
<td>1968</td>
<td>N</td>
</tr>
<tr>
<td>Helen Smith</td>
<td>11 1925-28</td>
<td>1906</td>
<td>Gladstone, Mb</td>
<td>1971</td>
<td>N</td>
</tr>
<tr>
<td>Isabel Cameron</td>
<td>11(2) 1926-29</td>
<td>1907</td>
<td>Carlyle Sask/Wpg, Mb</td>
<td>1972</td>
<td>N</td>
</tr>
<tr>
<td>Vera Chapman</td>
<td>11 1927-30</td>
<td>1906</td>
<td>Boissevain, Mb</td>
<td>1945</td>
<td>Y</td>
</tr>
<tr>
<td>Violet McMillan</td>
<td>11 1927-30</td>
<td>1907</td>
<td>Elgin/Bonita, Mb</td>
<td>1972</td>
<td>Y</td>
</tr>
<tr>
<td>Myrtle Crawford</td>
<td>12 1928-31</td>
<td>1906</td>
<td>Wpg/ Sask</td>
<td>1972</td>
<td>N</td>
</tr>
<tr>
<td>Anne Ross</td>
<td>12(2) 1931-34</td>
<td>1911</td>
<td>Ukraine/Wpg, Mb</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Beryl Seeman</td>
<td>12 1932-35</td>
<td>1911</td>
<td>Theodore, Sask</td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

* For those women who did not grow up in the same town, or district, in which they were born.
BIBLIOGRAPHY

I. Unpublished Primary Sources: Archival Collections

Provincial Archives of Manitoba

WGH, House Committee, Minutes, 1919-1929 MG 10 B 2

WGH, "House Rules for Nurses," August 1920 MG 10 B 10

WGH, Reports and Accounts, 1917-1943 MG 10 B 2

"Nurses and Their Work: Oral Histories of Nursing, 1920-1940" Oral History Collection, Interviewed by Kathryn McPherson

4-6 Duncan, Mary 22 June, 1987
1-3 Shepherd, Mary 18 June, 1987
7-8 McMillan, Violet 23 June, 1987
9-10 Parker, Grace 25 June, 1987
11-13 Lytle, Mabel 30 June, 1987
14-16 Cameron, Isabel 1 July, 1987
17-18 Paulson, Florence 1 July, 1987
19-20 Chapman, Vera 2 July, 1987
21-22 Seeman, Beryl 8 July, 1987
23-25 Cross, Ingibjorg 20 July, 1988
26-29 Mann, Josephine 22 July, 1988
30-31 Smith, Helen 3 August, 1988
32-34 Irwin, Olive 3 August, 1988
35-36 Ross, Anne 4 August, 1988
37-40 Crawford, Myrtle 5 August, 1988
41-42 McGilvary, Irene 29 April, 1987

National Archives

Canadian Nurses Association, Minutes, 1920-1940

Registered Nurses Association of Ontario

E. MacPherson Dickson, "Report on the Survey of the Field of Nurse Training" (1924).

Vancouver City Archives

VGH House Committee, *Minutes* Add MSS 320 Series 'A'


St. Boniface General Hospital, School of Nursing, Archives

St. Boniface General Hospital School of Nursing. "History" no date.

Vancouver General Hospital Nurses Alumnae Association Archives


Winnipeg General Hospital Nurses Alumnae Association Archives

WGH School of Nursing, *Blue and White*, 1920-1940.


Senior Lecture Notes, 1 October 1910 - 16 January 1911.

Manitoba Registered Nurses Association

MARN, Executive Committee, Minutes, 1920-1940.

MARN, Board of Managers Directors, Minutes, 1920-1940.

MARN, Annual and Quarterly Meeting, Minutes, 1920-1940

MARN, Central Directory Committee, Reports, 1922-1945

"Registration Act, Constitution and By-Laws, 1935" (Assented to February 15th, 1913, Amended...April 25, 1929).

MARN, "Binoculars Lifted!" 7 May 1948.

MARN, "Minimum Monthly Salary for General Staff Nurses in Manitoba". 1942.

MARN, Biographical File.

MARN, Registration Cards, 1920-1940.

University of Manitoba. Examination for Nurses' Registration, 1931.

Margaret Street. "A Nurse's Hallmark of Quality", Talk to the Manitoba Student Nurses Association, 12 January, 1945.

MARN. "Minimum Standards and Recommendation for Manitoba Schools of Nursing As Required by the Manitoba Association of Registered Nurses," 1941.

MARN. "Minimum Curriculum for Approved Schools of Nursing in the Province of Manitoba," 1928-1941.

CNA. "A Submission by the Canadian Nurses Association to the Honourable Minister of Pensions and National Health", November 1941.
MARN, "The History of Nursing in Manitoba," no date (1970?).


MARN. Brief presented to the Select Health Services Committee," 1 April 1947.

Letter, E.N. Weir (Graduate Nurse, Misericordia Hospital 1932) to MARN, Mission City B.C., 3 January 1971.
II. Unpublished Primary Sources: Private Collections

Myrtle Crawford, Winnipeg, Manitoba

Ruby Bowman, Notebook, 1925-1928

Myrtle Bowman, Notebook, 1928-1931

Kathryn McPherson, Vancouver, British Columbia

Harriet Pentland, interview by Kathryn McPherson, Tape recording, Winnipeg, Manitoba, 13 June 1986

Cali Dunsmuir, interview by Kathryn McPherson, Tape recording, Vancouver, B.C. September 1986

Jessie Law, interview by Kathryn McPherson, Tape recording, Vancouver, B.C. September 1986


Provincial Board of Health of Manitoba, "Practical Hints for Checking the Spread of Infectious Diseases" (Manitoba, n.d.)

"Edna Mildred Wilson Biography", no date.

Wilma Nicol, Brandon, Manitoba

Mary Shepherd, Winnipeg, Manitoba

Municipal Hospitals, "Staff Record", November & December 1928.

Municipal Hospitals, "Student Record Book," August 8, 1927 to August 27, 1928.


Letters, Mary Martin, Superintendent of WGH School of Nursing to Mary Shepherd, 6 January 1925; 11 February 1925.

WGH School of Nursing, "Requirements for Admission" 1924-1925.

Letter, MAGN to Mary Shepherd, 21 February 1929.

MARN, "Schedule of Rates and Hours for Members of Manitoba Nurses' Central Directory," 26 November 1928.

III. Published Primary Sources

American College of Surgeons, American and Canadian Hospitals: A Reference Book Giving Historical Statistical and Other Information. (Minneapolis: Midwest Publishing Company, 1933 & 1936).

American College of Surgeons. Bulletin, VIII, no. 1 (January 1924)


Canadian Nurses Association, A Proposed Curriculum for Schools of Nursing in Canada, April 1936.

Canadian Nurses Association, Canadian Nurse, 1905-1940

City of Winnipeg, Municipal Annual Reports, 1919-1940.


Manitoba Medical Association *Review*, 1935-1939


"The Nurse will be Reinstated." Halifax *Herald*, 28 December 1884, p. 8b.


Weir, G.M. *Survey of Nursing Education in Canada*. Toronto: The University of Toronto Press, 1932.
IV. Reference Works Consulted


V. Articles, Papers, and Addresses


Street, Margaret M. "Canadian Nursing in Perspective, Past, Present and Future." An address presented at the University of Alberta, November 15, 1974. (Canadian Nurses Association, 1974).


VI. Books and Theses


Cavers, Anne S. Our School of Nursing 1899 to 1949. Vancouver, 1949.


---


---


Limited in association with the Institute of Canadian Studies, Carleton University, 1979.


Wagner, Frances E. *Eighty Years of Grace.* Winnipeg: Grace General Hospital, Publishers.


Whittaker, Joanne. "'Dogs and Seals are Trained, Nurses Are Educated. Aren't They?' Nursing Education in Canada, 1972-1930." B. A. essay, University of Victoria, 1984.

Woodsworth, J. S. *Strangers at Our Gates.* Toronto: Missionary Society of the Methodist Church, 1909.