

**CURING SOCIETY'S ILLS:
PUBLIC HEALTH NURSES AND PUBLIC HEALTH NURSING IN
RURAL BRITISH COLUMBIA, 1919-1946**

by

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Curing Society's Ills: Public Health Nurses and Public
Health Nursing in Rural British Columbia

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Abstract

This thesis examines rural British Columbia's public health nurses during the formative years of the preventive health care system, 1919-1946. These nurses experienced a way of life that distinguished them from the hospital and private-duty nurses who so far have monopolized the attention of modern scholars. By utilizing a definition of public health nursing based on prevention, and emphasizing the public health nurse's role as a reformer, this thesis argues that a coalition of reform forces created a demand for public health and launched British Columbia's Provincial Public Health Nursing Service after World War I. Within this system, public health nursing, with its 'gospel of health,' promised women both personal independence and professional satisfaction with their contribution to society. This independence and satisfaction was, however, often won at the cost of isolation, loneliness and overwork as these women were frustrated by uncooperative local bureaucrats, as well as the ignorance, resistance and poverty of their clientele.

Using a definition and periodization that reflects the distinct nature of the profession, this thesis helps revise the history of public health nursing. In Canada, four branches of nursing — hospital, private-duty, visiting, and public health — emerged. Less tied than the others to the developments of curative medicine or the growth of hospitals, public health nursing can best be understood as a critical component of the social gospel and the 'missionary zeal' that characterized middle-class activism during the early twentieth century. Placing public health nursing within a social reform context, this thesis examines the duties, expectations and lives of pioneer public health nurses in rural British Columbia. Relying on the voices of these pioneering women, as heard through their reports, as well as a variety of other sources, this thesis illuminates an important area of women's paid work and British Columbia's rural past.

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Introduction

Curing Society's Ills: Public Health Nurses and Public Health Nursing in Rural British Columbia, 1919-1946

Historians have tended to place the public health nurse in a position of either exaltation or obscurity. Traditional nursing history, often written by the nurses themselves, has frequently portrayed public health nurses as a valiant group of pioneering heroines who sacrificed all for the public good. This genre offers very little in the way of critical interpretation, envisioning every step as part of the inevitable march toward today's modern nursing profession. In response to this largely celebratory assessment, a revisionist version of nursing history has recently developed with a much more critical investigation of nursing's past, especially the nursing elite's goal of professionalization. For all its insights, this new interpretation concentrates on curative medicine's hospital and private-duty nurses, while neglecting the unique role of preventive medicine's practitioner, the public health nurse. Part of a broader preventive reform program, public health nursing's agenda was quite separate from curative medicine's drive to develop a medical hierarchy for the emerging modern hospital system. The subordination of public health nursing in studies of hospital and private-duty nursing has hitherto obscured the distinct nature of public health nursing. The history of public health nursing needs special consideration which focuses on the connection between preventive medicine and social reform rather than such developments as the advances in curative medicine and the growth of hospital bureaucracy.

This exploration of the history of public health nursing in rural British Columbia will examine public health's original 'front-line' workers during the formative years (1918-1946) of the preventive health care system, in the province which was home to the first public health nursing diploma program in the Empire. By utilizing a definition of public health nursing based on prevention, and emphasizing the public health nurse's role as a

reformer, this thesis argues that public health nursing promised women both personal independence and professional satisfaction with their contribution to society. However, this independence and satisfaction was won often at the cost of isolation, loneliness and overwork. These exceptional women were often frustrated by uncooperative local bureaucrats, as well as the ignorance, resistance and poverty of their clientele. British Columbia's pioneer rural public health nurses managed personal and professional lives that were a good deal more complicated than the traditional nursing history would indicate. They also experienced a way of life that distinguished them from the hospital and private-duty nurses who so far have monopolized the attention of modern scholars.

Until recently, nursing history has remained predominantly the preserve of the nursing profession itself. Aimed at providing and preserving a rich heritage, this traditional genre commonly offers only a celebratory treatment of a homogeneous vocation that fought and won its right to professional status. According to its champions, the nursing occupation has been 'graced' with the presence of an articulate and self-conscious elite. This elite, by promoting their ideal of the "professional" nurse in journals, surveys, reports, manual and even novels, and by writing a number of histories have interpreted "the development of their occupation in the image of their own hopes and aspirations."¹ Comparing the appalling conditions and lack of acceptance faced by nurses in the distant past to their present situation, these nursing historians have dramatized progress from drudgery and sacrifice to participation in a 'noble' profession. This progressive model of nursing history simply traces the steps along nursing's road to professional status. Moreover, these histories regard nursing as a homogeneous monolith and rarely examine the internal divisions within the occupation. This progressive model not only ignores many of the less attractive aspects of nursing's history, but it also largely avoids discussion of the social and political context in which the nurses worked and the divisions among different types of nursing (hospital, private-duty and public health). Finally, it emphasizes the nursing elite and their labours, rather than the majority of nurses and their duties.² In

keeping with this emphasis on a small corps of leaders, nursing history has centred on the biographies of notables. Canada has added its own collection of 'real' nursing saints to the many British and American nursing histories which elevate Florence Nightingale to virtual sainthood.³ With this heritage, it is therefore no surprise that Canada has contributed significantly to celebratory nursing history with its own brand of nursing hagiography.

Several recent studies have tried to redress the deficiencies in nursing history that are implicit in the progressive model. Although the birth of social history did not initially spark great interest in a reconsideration of nursing's past, it provided a new perspective by which scholars have re-examined society. Most significantly for the history of nursing, social history transformed the understanding of medical history and encouraged the growing fields of both labour history and women's history. The emergence of these fields has offered models and methods for historians of nursing to take the focus away from the administration and political change, and center on the experiences and lives of the individual women. Countering the progressive model, revisionist nursing history thus offers a critical look at the nursing elite and the goals of professionalization.

The leading American nursing revisionist, Barbara Melosh, influenced by the new women's history and the recent work in the social history of medicine, has offered a critical and provocative new appraisal of nursing. In her book, *"The Physician's Hand": Work Culture and Conflict in American Nursing*, Melosh raises the examination of nursing to a new standard and shatters the previously envisioned monolith of nursing by distinguishing first among the three branches of nursing — hospital, private-duty and public health — and second between the elite and the 'rank and file.' Melosh uses a critique of the professionalization process to counter the progressive model's championship of the struggle for professional status. The nursing elite consciously emulated the conservative professionalization efforts of doctors in the nineteenth century through the pursuit of higher education qualifications and standardized training schools. This policy, ultimately unsuccessful, aimed to attain the privileged position that the largely male medical

profession enjoyed. Melosh argues that this goal of attaining professional status produced a consensus only among the nursing elite and proved in fact a source of contention for the 'rank and file.' The goals and experiences of the lower echelons of nursing were often different than those of their leaders.

In "*The Physician's Hand*," Melosh effectively demonstrates the destructive impact of the elitist ideas of professionalization. In her attempt to establish the conflict between the nursing elite and the 'rank and file', Melosh uses the demise of public health nursing in the U.S. as a useful case study. In the United States, public health services were eventually absorbed into the hospital system and public health nursing met its official demise in 1952 when the National Organization for Public Health Nursing (N.O.P.H.N.) folded. Countering the traditional account which laments this event,⁴ Melosh critically attributes the N.O.P.H.N.'s dissolution to the public health nursing leaders' unwise pursuit of elite professional status based on the superior educational qualifications of public health nurses. As public health gained acceptance with the medical profession through the efforts of the public health nursing elite, doctors and hospital administrators asserted control and eliminated the independence of public health nursing. "As the institutions and practitioners of mainstream medicine embraced the public-health message, the nurse's special role was undercut."⁵ In the American case, an examination of public health nursing in the same context as the other two branches of private-duty and hospital nursing is quite effective for critiquing professionalization policies of nursing. Lost in this approach however, is the illumination of nurses' work and experiences which has become of special interest to modern social and labour historians.⁶

Melosh's 1982 study was followed five years later by Susan Reverby's important work, *Ordered to Care: The dilemma of American nursing, 1850-1945*.⁷ By disposing of the traditional view of nurses as professionals and examining the 'rank and file' nurses, Reverby is able to illuminate many previously hidden aspects of nurses as both workers and women. She argues "that nursing is a form of labor shaped by the obligation to care."⁸

By unraveling and revealing the connection between nurses' obligations as women to care, with the failure of American society to value caring, she takes a necessary step toward illuminating the causes of the current crisis in North American nursing.

Karen Buhler-Wilkerson's *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930* represents the first work on public health nurses to come out of the Melosh's revisionist school.⁹ In *False Dawn*, Buhler-Wilkerson addresses the question of the demise of public health nursing in America by tracing its origins and development of both the National Organization for Public Health Nursing and the Red Cross Rural Nursing Service through the first three decades of the twentieth century.¹⁰ As the only major work on the history of American public health nursing, Buhler-Wilkerson's detailed study misses an opportunity to make an important and much needed contribution to the history of nursing — a comprehensive discussion of the definition of public health nursing. She never deals directly with the problem of defining public health nursing. Several times, she refers to the self-definition problems of these nurses as their name evolved from 'district' to 'visiting' to 'public health' nurse,¹¹ but she never attempts to analyze the underlying issues raised by these name changes. The fate of American public health nursing system, really a visiting nurse system that died out because of the rise of hospitals, was not the case in Canada.

Buhler-Wilkerson's, Reverby's and Melosh's studies are not directly transferable to the Canadian situation. The development of preventive health is one of the areas where Canada and the United States evolved differently. In the United States, with the growth of private hospitals and the influence of the powerful American Medical Association, medicine was strongly shaped into a curative rather than preventive form.¹² In Canada, with different forces involved, such as large nationwide organizations and a more interventionist government, preventive health was allowed to develop more fully.¹³ The growth of hospitals that was a critical development in the demise of the American visiting nurse

system did not have the same impact on the public health system in Canada. Canadian public health nursing took a different form than its American counterpart.

However, the Canadian case can be profitably examined through the application of the Melosh-inspired school of American nursing history. Greatly influenced by Melosh, Kathryn McPherson is the first historian to attempt such a revision of nursing history in Canada. Using aspects of Melosh's methodology, in her doctoral thesis "Skilled Service and Women's Work: Canadian Nursing, 1920-1939,"¹⁴ McPherson examines the structure and content of hospital and private-duty nursing work during the interwar years, and serves as a critical contribution to Canadian nursing history. She builds on the investigation of both hospital and private-duty nursing begun in her Master's thesis, "Nurses and Nursing in Early Twentieth-Century Halifax," which studied all three sections of nursing in Halifax, Nova Scotia.¹⁵ In each of these studies, McPherson amalgamates the methodology of Melosh with the dynamic field of Canadian labour history to revise our understanding of Canadian nursing history by placing the nurse-worker within the structure of the modern factory-like hospital and the evolution of the medical hierarchy.¹⁶

While McPherson gained a great deal of insight into Canadian nursing through the transfer of Melosh's American methodology and ideas, her work falls victim to problems of definition. The meaning of the term 'public health nursing' is not the same in both the United States and Canada. In the late nineteenth century visiting nurse organizations were developed in both countries. Canada modeled its system on the pattern of the Queen's Nurses of England and developed a national visiting nurse organization, the Victorian Order of Nurses (V.O.N.).¹⁷ In the United States, a similar system was developed, but it was based on local, rather than national, organizations. Regardless of the differing structures, both labeled their workers public health nurses and both offered similar services — visiting nurses gave "bedside care in the homes of the community on a visiting basis."¹⁸ However, after the First World War, the path of public health in Canada and in the United

States diverged. A new vocation of 'public health nursing' was created in Canada that had its emphasis on prevention, education and reform, rather than curative bedside nursing.¹⁹ No such branch of nursing emerged in the United States and American visiting nurses continued to be known as public health nurses. In Canada, the two branches of visiting nursing and public health nursing existed side by side. McPherson's direct transfer of the American model misses these distinctions between the American and the Canadian developments.

Because of the differences between the American and Canadian cases, McPherson's Master's thesis is very effective for hospital and private-duty nursing, but it remains deficient for public health nursing. For the period prior to World War I, her study examines only V.O.N. nurses. Since these V.O.N. nurses were employed almost solely in bedside nursing and were not engaged in preventive medicine, they differed only slightly from both their visiting nurse counterparts in the United States or those engaged in private-duty nursing. McPherson's definition of public health nursing does not capture the "missionary zeal" of the early "health gospel" that arose in Canada after the First World War.²⁰ These public health nurses were not just engaged in wage labour, they were engaged in reform. They were not only very different than hospital or private-duty nurses but were also quite different than the visiting nurses of the Victorian Order, whom McPherson has classified as public health nurses.²¹ As distinguished from visiting nurses, public health nurses were not hired to do bed-side nursing — their work was not curative, but preventive. According to John Murray Gibbon and Mary Mathewson:

The old idea of nursing was more or less limited to the cure of a sick patient, but the trend of modern thought is that prevention is better than cure. The Public Health Nurse must, therefore, be a teacher of healthy living conditions to parents and children, and to municipal and school authorities, rather than just a bedside attendant carrying out the doctor's orders.²²

Although they provided an important philanthropic service, early V.O.N. nurses were not representatives of the general public health movement.²³ Public health nursing, with its emphasis on prevention, is better understood within the context of social reform.

Other studies have not neglected the preventive nature of public health nurses' work. Recently, two Canadian examinations of public health nursing have appeared which use the context of social reform and an emphasis on the nurses' roles as educators and agents of prevention. Simultaneously, both Cynthia Abeele at Guelph University and Meryn Stuart at the University of Pennsylvania, examined maternal-child welfare and public health nursing in rural and northern Ontario, during the interwar period.²⁴ Both conclude that there was a tremendous difference between ideology and experience.²⁵ "It was widely believed that the special power of one woman - the public health nurse - would literally save Canadian babies from the jaws of death and ensure the stability of the family unit"²⁶ simply by educating their mothers in modern preventive care. The experience of the public health nurses differed widely, however, from this utopian and naive view. Both Abeele and Stuart focus on the short-lived government-sponsored child welfare program in Ontario where they found that "the nurses themselves were frequently frustrated by ... the irremediable poverty they encountered.... All the campaigners could muster in the form of modern advice and instruction in modern methods could not compensate for the real needs of these mothers and children."²⁷

While these investigations make important contributions to the understanding of rural maternal-child welfare in interwar Ontario, they are ineffectual in providing a great deal of insight into the nature of public health nursing work in general. Each study illuminates the differences between the federal and the Ontario provincial reformers' idealistic goals, and the poverty of Ontario's rural communities. Both Abeele's and Stuart's examinations focus on how Ontario, through a small, short-term series of public health demonstrations, hoped to 'demonstrate' to the local communities the benefits of

funding their own local public health nursing service. While Stuart does a very commendable job, neither Abeele nor Stuart are able to reveal as much as one would like about either the nurses themselves or their work as the Ontario program of demonstrations quickly succumbed to the reality of community poverty. Contrary to the Ontario system of demonstrations that only lasted between 1920 and 1925, the longer-lived British Columbia public health nursing system did not have as great a reliance on community financial support. A British Columbia case study thus offers the opportunity to examine public health nurses and their work over a longer period of time, without being sidetracked or distracted by political and financial machinations.

Of the few works that acknowledge the separate contribution of public health nurses, only three deal with the case of British Columbia. However, these three works, John Gibbon and Mary Mathewson's *Three Centuries of Canadian Nursing*, Monica Green's *Through the Years with Public Health Nursing* and Nora Whyte's "Provincial Public Health Nursing in British Columbia from 1939-1959: A Social History," continue in the tradition of celebratory history.²⁸

Gibbon and Mathewson's 1947 'classic' national study of nursing history, *Three Centuries of Canadian Nursing*, is the outstanding Canadian example of descriptive hagiography. Yet, by including a separate chapter on public health nursing that includes sections on British Columbia, Gibbon and Mathewson break with the general pattern of conventional studies which subsume public health nurses into mainstream nursing. Their separate treatment of public health nursing and their observation that, "Canadian nurses are playing a notable part in the promotion of Public Health as well as caring for the individual patient"²⁹ makes it clear that they discern distinct divisions within the larger nursing profession. However, Gibbon and Mathewson's contribution to a re-evaluation of nursing history ends there. Sponsored and funded by nurses and nursing across Canada, Gibbon and Mathewson perpetuate the glorification of a select elite. Even their title, *Three Centuries of Canadian Nursing*, indicates that they intend to trace modern Canadian nursing

directly back its roots in Catholic sainthood. Gibbon and Mathewson thus demonstrate their inability to venture far from the traditional mold of nursing hagiography.

Other than a brief mention by Gibbon and Mathewson, public health nursing in British Columbia remained largely undiscussed by historians until the 1980s. Green's and Whyte's studies, published in 1983 and 1988 respectively, have both focused exclusively on public health nursing in British Columbia. Green, writing her book after her retirement as British Columbia's Director of Public Health Nursing, and Whyte, writing her work as a partial fulfillment of her Master's degree at the University of British Columbia's School of Nursing, both had a great deal invested in the portrayal of public health nursing. Despite their obvious acknowledgement of public health nursing as a distinct branch, these treatments of British Columbia's public health nursing follow the basic tenets of the progressive model.

Green recounts the major events and developments in the history of public health nursing in British Columbia, from the 'rough and rugged pioneer days' (1871-1919) to the modern efficiency of the 1970s. Delving into areas commonly ignored by traditional accounts, Green has utilized nurses' reports and accounts of their experiences to explore the nature of public health duties. This anecdotal but disjointed account offers brief glimpses of B.C. public health nurses' work but raises important questions about women's satisfaction with their work and how they saw their role in the community. By emphasizing nursing leaders and administrative change, Green muffles the voices of the practitioners and thus fails to examine the nature of the nurses' experiences and their work.

Despite its promising title, Whyte's "Provincial Public Health Nursing in British Columbia from 1939-1959: A Social History" also continues the progressive model of nursing history. Whyte acknowledges the changing nature of the study of history as researchers "embrace the principles of social history," but the nature of these 'principles' remains unclear.³⁰ Again, Whyte touches on key problems without developing them. For example, in a section entitled "The Public Health Nurse's Role", she notes that "public

health nursing was demanding in the forties and fifties, but it was worthwhile because the nurses knew that their work was important and 'made a difference' to the health of the community."³¹ While Whyte frequently demonstrates such insight, she fails, however, to expand and explore exactly why this work was important, the attitude of the nurses to their work and the difference this work made to the community. The reader is left to ponder the implications of such statements.

Whyte's periodization is also problematic. According to Whyte, 1939 "marked the beginning of an era," with the establishment of the Division of Public Health Nursing within the Provincial Board of Health.³² However, in reality, this minor administrative change was relatively insignificant. The real changes would wait until after the war when the creation of the Department of Health and Welfare (1946) accompanied a tremendous increase in government funding and dramatic expansion of services. Whyte is quite correct in asserting that "the decade of the 1950s was a period of change and expansion for public health nursing."³³ The closing date for her study, however seems to have no particular rationale beyond the fact that it marked "the close of the decade."³⁴

Despite its short-comings, Whyte's study provides detailed information on the programs offered by public health nurses and the organization of public health services in the 1940s and 1950s. Examining nursing education and the influence of non-governmental agencies such as Victorian Order of Nurses (V.O.N.) and the Red Cross, Whyte acknowledges the importance of these aspects to the development of public health in British Columbia. However, this initial investigation into these previously ignored areas requires further, in-depth research.

The present nursing historiography thus adds up to a picture which either fails to appreciate the distinct nature of public health nursing in British Columbia or conflates the history of public health nursing with the history of professionalization. When discussed at all, public health nursing is often subsumed in studies of hospital and private-duty nursing. When at the centre of the narrative, as with Abeele and Stuart, it often fails to investigate

the nurses and their work. Therefore, there is a need to turn to other areas of historical work.

The current work in the history of education offers a great deal to studies in the history of public health nursing. Education history is relevant to public health nursing history in two ways — first, in the interwar period, the profession of teaching serves as a useful comparison to nursing; and second, studies of public health education and reform in schools, especially the work of school nurses, offers a different perspective on nurses' work. Henry Esson Young made the connection between the two professions in 1926 when he described British Columbia's corps of public health nurses: "They are truly teachers and we prefer to call them public-health teachers rather than public-health nurses."³⁵ Margaret Kerr, public health nurse for Nanaimo, was also convinced that public health nurses shared a great in common with teachers:

The analogy betwixt Public Health Nurses and teachers is very close. "Theirs (the teachers and nurses) is the responsibility of opening the doors of the mind of each following generation, and letting in the light. It is they who must call the attention to what is passing outside the windows of that railroad-car, going at express speed, in which we are making the journey of life. Without the teachers, the whole journey of the train would be spent by most travellers in the dining-car."³⁶

In the eyes of many, public health nurses and teachers shared a great deal.

The similarity of the plight of British Columbia's rural schoolteachers and rural public health nurses is best exemplified by the similar problems they encountered while scattered throughout the young province. While Alison Prentice and Marta Danylewycz have contributed a great deal of information on the history of teachers — especially in Ontario and Quebec in the late nineteenth century³⁷ — more relevant to this study of public health nurses in rural British Columbia is J. Donald Wilson's work on B.C.'s rural schoolteachers.³⁸ Especially in his work on women teachers, Wilson successfully balances the two attributes of rural teaching: on the one hand, "the job furnished a woman with some independence" and "satisfied a sense of adventure," while on the other hand, "loneliness, isolation, difficult and unfriendly trustees, parents, and landlords confronted

many teachers.”³⁹ The similarities between the situations facing nurses and teachers is well illustrated by two cryptic warning messages — schoolteacher John Gibbard was left a note in his desk by his predecessor that simply read, “[m]ay the Lord have mercy on you”⁴⁰ while public health nurse, Mary Henderson, gave a strikingly similar message to new nurses: “[i]t is all very overwhelming at times, and my sincerest sympathy goes out to the new graduate ‘turned loose’ in a district of her own.”⁴¹ Wilson’s sensitivity is much needed in any analysis of a ‘woman’s profession,’ and unfortunately is too often missing from ‘nursing’ accounts that regard public health nursing as simply emancipating.

Of course, public health nursing and schoolteaching were different professions. Public health nurses were better educated than their teaching counterparts and, as a consequence, were older. They also were not at the mercy of a locally elected board or in direct contact with any senior supervisors — problems that plagued rural teachers.⁴² While public health nurses did work in conjunction with a local committee, this body did not provide all the financing nor did it have the power to hire and fire indiscriminately. Moreover, nurses were sent to the rural districts to educate parents and children alike and as a result were not as directly accountable to parents concerning the education of their children. They were practitioners, not proletarian. These factors, combined with her uniform, automobile and medical bag, gave the public health nurse considerably more authority, independence and prestige within the community.

In addition to providing a point of comparison, the history of education also overlaps with the history of public health nursing in the reformers’ concern for the health of schoolchildren. Neil Sutherland’s “Social Policy, ‘Deviant’ Children, and the Public Health Apparatus in British Columbia Between the Wars” and *Children in English-Canadian Society: Framing the Twentieth-Century Consensus*, both offer a thorough examination of public health reform in Canadian schools.⁴³ Kari Dehli’s “‘Health Scouts’ for the State? School and Public Health Nurses in Early Twentieth-Century Toronto” provides a thoughtful and provocative look at Toronto’s first school nurses, illuminating

the operation of this early urban system of school inspection and home-visiting.⁴⁴ Studies of public health education and reform in schools, such as the work of Sutherland and Dehli, provide a fresh approach to the history of the work done by public health nurses.

While the educational history approach provides a great deal of insight into the forces behind the nurses' work, these studies often ignore the needs, goals and experiences of the public health nurses themselves. As Kari Delhi herself concludes in her article, we "need to know a lot more about nurses' own experiences of their work, both their pleasures and achievements, as well as their difficulties and shortcomings."⁴⁵ This thesis will thus examine public health teaching, addressed by the historians of Canadian education, from the point of view of the public health nurse, and reveal the duties, expectations and lives of public health nurses. It will also challenge the virtual exclusion of public health nursing and the neglect of its preventive nature, made by both the traditional and revisionist nursing histories by providing a definition and periodization which reflect the distinct nature of public health nursing.

This thesis will then examine British Columbia's public health nurses in three parts. First, to provide a background, the forces leading up to the launching of the B.C. Provincial Public Health Nursing Service after WWI will be briefly examined. The interests of social reformers, the government, the public, the nursing elite, and the 'rank and file' nurses all coalesced immediately after the war to create a demand for a generalized public health nurse position in rural British Columbia which was instituted in 1919. Second, this thesis will examine both these pioneer nurses and rural public health nursing. Public health work was filled with a variety of challenges and great rewards as the local nurses were often left to their own devices to determine the manner in which to spread the gospel of health to the province. While this could be a daunting task, these highly trained and well motivated women often met the challenge successfully and thus reaped the personal and professional rewards. While rural public health nursing offered the chance of these benefits, it at the same time provided many frustrations. Therefore, third, this thesis

will examine the disillusionment of B.C.'s public health nurses. To be alone in these small, isolated rural communities throughout the province not only granted independence, but also loneliness and overwork. Through these three stages, this thesis will illuminate public health nurses and public health nursing in rural British Columbia in the inter-war period.

In order to examine public health nurses and their work, this thesis will rely mainly on the voices of the nurses themselves. Spread throughout a rugged province, usually stationed alone, B.C.'s public health nurses realized their need for a mutual support group. The Provincial Board of Health obliged by collecting letters and publishing them in a bulletin for the expanding Public Health Nursing Service. As stated in the introduction to the first issue (1924) of the *Public Health Nurse's Bulletin*:

It is the purpose of the Provincial Board of Health to assist the Public Health Nurses to issue a bulletin which will be a medium for the exchange of ideas in connection with their daily work. We all profit by experience gained when applying our theoretical knowledge to problems that arise and which may be classed as purely local. Yet similar conditions in other districts may have to be met, and one nurse's experience when told through the bulletin may be of great help to others. With this object in view the nurses have been asked to send in from time to time an account of their trials and tribulations, giving or asking for advice.⁴⁶

The *Public Health Nurses' Bulletin*, published annually from 1924 to 1939, contains a window through which to view the lives and times of the nurses, dealing with their work, their attitudes and the reception they received from the community.

British Columbia's pioneer public health nurses were an extremely articulate group. Their discussions in the bulletin include a balanced variety, ranging from details of the daily mundane routine to more dramatic emergencies and journeys. Throughout their vivid contributions, they demonstrate an awareness of both their 'mission of health' and the unusual nature of their daily adventures. The emotional tone of their letters is also varied. While some of the nurses displayed overflowing enthusiasm for their work, others showed frustration with the seemingly overwhelming obstacles facing them. A few even went from one extreme to the other over several years. Overall, the voices of these early public health

nurses as heard through the *Public Health Nurses' Bulletin* adds rich texture and bright colour to our understanding of both this branch of women's paid work and British Columbia's rural past.

To complement this rich source, other primary sources were also consulted.

Professional journals such as the *Canadian Nurse* and the *Public Health Journal* were used to trace the developments and professional concerns in nursing, public health nursing and public health. The British Columbia Provincial Government annual reports also were used to get a glimpse of the overall government policy and especially the views and goals of the Provincial Officers of Health, the leading figures in the shaping of British Columbia health policy. These sources, combined the voices of the nurses, allows for a careful examination of this aspect of women's work.

By providing a definition and periodization that reflects the distinct nature of public health nursing, this thesis hopes to provide a 'new-revisionist' history of public health nursing in rural British Columbia between 1919 and 1946. Unlike the three branches of American nursing, this thesis argues that there were four branches of Canadian nursing — hospital, private-duty, visiting and public health. Public health nursing was distinct from the three other branches of nursing as it was not part of the modernization of curative medicine or the growth of hospitals. It was instead a critical component of the social gospel and the 'missionary zeal' that characterized middle-class activism during the late nineteenth and early twentieth centuries. The connection of public health nursing to the reform movement helps explain, far better than any link to hospital and curative medicine, the unique nature of public health nursing. By separating public health nursing from visiting nursing, this thesis will work within a social reform context and periodization that will illuminate this fourth branch of Canadian nursing through a study of the duties, expectations and lives of public health nurses.

Notes:

¹Barbara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), p.4.

²For examples of this genre of nursing history see Lavinia Dock, *A Short History of Nursing: From the Earliest Times to the Present Day* (New York: G.P. Putnam's Son's, 1920); Revised and reprinted by Isabel Stewart and Anne Austin, *A History of Nursing: From Ancient to Modern Times: A World View* (New York: G.P. Putnam's Sons, 1962); Tony Cashman, *Heritage of Service: The History of Nursing in Alberta*. (Edmonton: Alberta Association of Registered Nurses, 1966).

³Joining the ranks of French-born Canadian nurse "saints" such as Jeanne Mance, will be another nursing saint - Marguerite d'Youville. The founder of the *Soeurs Grises de Montréal* (Grey Nuns of Montreal), will soon be named the first Canadian-born saint by the Roman Catholic Church. *The Province*, Vancouver, March 27, 1990, p.14.

⁴Louise Fitzpatrick, *The National Organization for Public Health Nursing: Development of a Practice Field* (New York: National League for Nursing, 1975).

⁵Melosh, p. 157.

⁶For an example of twentieth-century labour history that emphasizes the nature of the work, see Craig Heron, *Working in Steel* (Toronto: McClelland and Stewart, 1988).

⁷Susan M. Reverby, *Ordered to Care: The dilemma of American nursing, 1850-1945* (Cambridge, New York: Cambridge University Press, 1987).

⁸*Ibid.*, p.1.

⁹Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930* (New York: Garland Publishing, Inc., 1989); This was preceded by her article of the same title, "False Dawn: The Rise and Decline of Public Health Nursing in America, 1900-1930," in *Nursing History: New Perspectives, New Possibilities* (New York: Teachers College Press, 1983).

¹⁰Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930* (New York: Garland Publishing, Inc., 1989), p.114.

¹¹Today, 'public health nurses' also have to deal with the addition of 'community health nurse' to their list of titles.

¹²Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Co., 1970).

¹³For more on the distinct traditions in Canadian and American medicine, see Margaret Andrews, "Rural Medical Practice in the Smelter West, 1898-1923: A Case-Study Comparison," *Canadian Bulletin of Medical History* (Vol. 6, 1989), pp.83-109; Theresa R. Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (New York: State University of New York Press, 1989), pp.59-74.

¹⁴Kathryn McPherson, *Skilled Service and Women's Work: Canadian Nursing, 1920-1939*, unpublished Ph.D. Thesis, Simon Fraser University, 1989.

¹⁵McPherson, *Nurses and Nursing in Early Twentieth-Century Halifax*, unpublished M.A. Thesis, Dalhousie University, 1982.

¹⁶McPherson, *Nurses and Nursing...*, p. 6.

¹⁷Florence H.M. Emory, *Public Health Nursing in Canada: Principles and Practice* (Toronto: MacMillan, 1953), p. 25.

¹⁸*Ibid.*, p. 29. Visiting nurses were also called district nurses.

¹⁹*Ibid.*, p. 33.

²⁰Phrases coined by McPherson and Melosh, respectively.

²¹McPherson, *Nurses and Nursing...*

²²John Murray Gibbon with Mary Mathewson, *Three Centuries of Canadian Nursing* (Toronto: MacMillan Co., 1947), p.314.

²³The term 'public health nursing' will be continued to be used solely in reference to the new branch of nursing that arose after the First World War that was primarily engaged in prevention and health education.

²⁴Cynthia Comacchio Abele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1918-1940," *Ontario History*. Vol.LXXX, No.3, September 1988; Abele, *Nations are Built of Babies: Maternal and Child Welfare in Ontario, 1914-1940*, Ph.D. Thesis, Guelph University, 1987; Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920-25," *Canadian Bulletin of Medical History*, Vol. 6, 1989; Stuart, 'Let Not the

People Perish for Lack of Knowledge: Public Health Nursing and the Ontario Rural Child Welfare Project, 1916-1930, Ph.D. Thesis, University of Pennsylvania, 1987.

²⁵Stuart, "Ideology and Experience....", p.113.

²⁶*Ibid.*, "Ideology and Experience....", p.112.

²⁷Abeelee, "The Mothers of the Land....", pp.201-202.

²⁸Monica Green, *Through the Years with Public Health Nursing* (Ottawa: Canadian Public Health Association, 1983); Nora Whyte, "Provincial Public Health Nursing in British Columbia from 1939-1959: A Social History," Master's thesis, School of Nursing, University of British Columbia, 1988.

²⁹Gibbon and Mathewson, p.vi.

³⁰Whyte, p.2.

³¹*Ibid.*, p.43.

³²*Ibid.*, p.5.

³³*Ibid.*, p.6.

³⁴*Ibid.*, p.6.

³⁵Henry Esson Young, *RPBH* (1926), p.6.

³⁶Margaret E. Kerr, "Teaching the Teacher to Teach," *Public Health Nurses' Bulletin* (Victoria: Provincial Board of Health, 1931), p.3.

³⁷For example see Marta Danylewycz and Alison Prentice, "Teacher's Work: Changing Patterns and Perceptions in the Emerging School Systems of Nineteenth and Early Twentieth Century Central Canada," *Labour/Le Travail* 17 (Spring 1986).

³⁸J. Donald Wilson, "I am Here to Help if You Need Me': British Columbia's Rural Teachers' Welfare Officer, 1928-1934," *Journal of Canadian Studies*, Vol.25, no.2 (Summer 1990), pp.94-118; J. Donald Wilson and Paul J. Stortz, "May the Lord Have Mercy on You": The Rural School Problem in British Columbia in the 1920s," *BC Studies*, no. 79 (Autumn 1988), pp.24-58.

³⁹Wilson, p.97 and p.98.

⁴⁰Interview with John Gibbard, retired schoolteacher, Vancouver, 24 February 1986, as quoted by Wilson and Stortz, p.24.

⁴¹Mary E. Henderson, "First Impressions," *PHNB* (1930), p.20.

⁴²Danylewycz and Prentice, "Teacher's Work....", pp. 68-70, and Wilson, pp. 94-95.

⁴³Neil Sutherland, "Social Policy, 'Deviant' Children, and the Public Health Apparatus in British Columbia Between the Wars," *The Journal of Educational Thought* (Aug. 1980), pp.80-89; Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1976). See also Jean Barman, "Reform and Its Limits, 1871-1929," *The West Beyond the West: A History of British Columbia* (Toronto: University of Toronto Press, 1991), pp. 202-235.

⁴⁴Kari Dehli, "Health Scouts" for the State? School and Public Health Nurses in Early Twentieth-Century Toronto," *Historical Studies in Education* (No. 2 1990), pp.247-264.

⁴⁵*Ibid.*, p.261.

⁴⁶Provincial Board of Health, *Public Health Nurses' Bulletin* (1924), p.1.

Chapter 1

A Front Porch in the Backwoods: Taking Public Health Reform to Rural B.C. , 1919-46

The period between Confederation and the end of the First World War was a time of dramatic change for Canadians. The direction the new nation was to take after 1867 was hotly debated. Although Canadians were concerned with their recent political transformation, they were even more concerned with the late nineteenth century's dramatic social and economic changes. Rapid industrialization and urbanization were not only producing the ugly landscape of the modern industrial city, but coupled with large scale immigration, were also threatening the structure of the Anglo-French society. It appeared obvious that the future of Canada as a new independent and industrializing nation would be drastically different from its colonial roots. In response to the political, social and economic problems facing the infant nation, a broad section of the middle class embraced reform. Public health concerns were central to much of this reform wave that wanted to transform Canada and shape its future — to cure “the collective ills of an industrializing society.”¹

In response to the problems of the day, a wide series of alternate visions arose. These visions ranged from women suffragists' fight for a more equitable society and the vote, to the Canada Firsters' spousal of imperialism, from the Knights of Labor's radical plan to restructure the workplace to John A. Macdonald's completely 'unradical' National Policy.² A broad spectrum of alternate visions mobilized those Canadians taking hard look at their 'new nation.' Middle-class Canadians banded together in a variety of causes, such as the social gospel, the women's movement, the city beautiful campaign, and the fight for progressive education, all aimed at tackling the problems of a modern world.³

Searching for a practical focus to ground their dreams, many would-be reformers turned to the scientific world.⁴ Preventive medicine, or the 'gospel of health,' appeared to

offer a sure method of curing many of society's "ills". The eradication of physical maladies would, it was often hoped, create 'a new and better world' through the systematic application of the new scientific discoveries. In Europe, scientists were making dramatic progress in the area of bacteriology. Pasteur's and Koch's advances and the resulting frenzy of investigation had launched the age of bacteriological discovery.⁵ The germ theory proposed that disease was not caused by 'vapours' from 'miasmas,' but by identifiable microbes. It was hoped these new advances would prevent, cure and eventually eliminate all contagious diseases.⁶ These new ideas attracted the attentions of reformers and health officials and created a new enthusiasm for scientific public health. Bacteriology firmly grounded public health in science.⁷ The increasing acceptance of the 'miracles of modern science' offered public health both the mandate and respect it had not previously enjoyed. Under the banner of science, Canadian social reformers now had the concrete methods, justification for action, and the credibility with both the public and the state that they needed.

Reform movements of every persuasion readily focused on concrete scientific 'cures' to social 'ills' — ills that were seen as threats to Anglo-Saxon society. The relatively high birth rates of the newly arrived 'foreign' immigrants, appeared to threaten both French and English Canadians with race degeneration or even race suicide, galvanizing them to conserve their 'rising generation.'⁸ In addition, high infant and maternal mortality rates added to fears and concerns.⁹ Public health promised to decrease both infant and maternal mortality as well as stamp out many of the greatest killers of the time, such as small pox, typhoid and diphtheria.¹⁰

Public health also offered social gospellers a step toward the achievement of their goal — the creation of the 'Kingdom of God on Earth.' With the increasingly apparent failure of the social gospellers' attempt to bring salvation to each individual, there was a fundamental shift to try to bring salvation to the entire society instead. According to

Richard Allen, "the demand to 'save this man, now' became 'save this society, now.'"¹¹ Expressing this shift in ideology, British Columbia's Provincial Officer of Health, former Minister of Education and Provincial Secretary, Dr. Henry Esson Young stated in 1920, "physical perfection must and does go hand in hand with spiritual welfare. There is no use to try to uplift the morals of the rising generation if the environment is ... materially immoral."¹² The wide application of public health would then promote 'cleanliness and godliness' to the society which had rejected individual evangelicalism. The new bacteriological discoveries thus offered frightened Canadians and frustrated social gossippers new scientific ideas that could be incorporated into their differing agendas.

As a result of this enthusiasm, during the late nineteenth and early twentieth century, urban Canadians, especially urban school children, were the recipients of a great deal of public health attention. The concern over industrialization and urbanization was linked to the belief that the city was the source of all that was evil and degrading. In their effort to 'save the rising generation', reformers rapidly applied the public health methods already in use in American cities.¹³ In Toronto, Vancouver and other major Canadian urban centres, turn-of-the-century doctors routinely inspected school children for 'defects', sanitary inspectors quarantined the households of school children found to be carriers of contagious disease, and voluntary organizations such as the Woman's Institutes and the Local Councils of Women set up safe milk dispensaries and well-baby clinics.¹⁴

To attain the goals of the reformers and implement the public health programs, a series of urban nurse specialists were also developed across the country. School nurses weighed and measured children and assisted doctors with school inspections, tuberculosis nurses operated chest clinics and followed up on contacts, visiting or district nurses, such as the Victorian Order of Nurses, made home visits to people who could not afford private duty nurses, and child welfare nurses worked with the women's organizations to promote maternal and infant welfare through such preventive measures as infant clinics and pre-natal

visits. By the First World War, all major Canadian cities had public health departments and a plethora of public health professionals combating the 'ills' of urban society.¹⁵

In contrast to the urban public health reform, well under way by the First World War, rural Canada remained still largely unaffected.¹⁶ Champions of rural living such as Nellie McClung argued that: "we all know that the country is the best place in which to bring up children [and] it is very desirable for the world that people should be born and brought up in the country with its honest, wholesome ways learned in the open."¹⁷ Largely, the rural areas had been ignored because of the widely held belief that the country was 'naturally' healthy and because it was difficult to evolve efficient and cheap administration outside city limits. In July 1918, in his Chairman's Address to the Child Welfare Section of the Canadian Public Health Association, pediatrician Alan Brown stated that Canadian bulletins on child care gave him "the impression that they were not intended for use outside the city limits."¹⁸ Brown's observation and others like it,¹⁹ demonstrated that as of 1914, the rural areas were not a part of the existing public health apparatus.

However, World War I changed perceptions. The rejection of many army recruits as unfit during the war shocked the nation and sparked concern over the health of Canadians, especially its rural youth.²⁰ As Monica Green former B.C. Director of Public Health Nursing stated in her history of public health nursing "the health of the young which should have been at its peak was found wanting."²¹ British Columbia's Provincial Officer of Health described the new public concern for health brought on by the war publicity:

The public are taking such an interest in health matters, and are realizing from the study of the figures furnished by the military authorities of the number of defects who were rejected on enlistment, that something will have to be done in the way of bringing about a better physical condition of our population.²²

The war thus shattered the long-held myth surrounding the relative 'healthfulness' of the country versus the city. At the close of the war, city life was increasingly seen as modern and cosmopolitan, while rural life was seen as retarding and backward.²³ In addition, as

reflected by the rise of the Progressive Party in the prairie west and the United Farmers of Ontario, rural residents displayed an increasing determination to receive the benefits of a modern urban world. Not surprisingly, one of the first political agendas after the war was to extend the conveniences of the city to the country.

The war also had an educational impact on Canadians. Although no major medical discoveries were made during the war, the military had systematically imposed the 'rules of health' in the war camps in Britain and significant progress had been made — for the first time disease was not a greater killer than battle.²⁴ Young, convinced of the beneficial effect of World War I on the attitudes of the people of British Columbia toward a public health system, claimed that prior to the Great War:

The voices of public health authorities were crying in the wilderness. The public was not concerned. Epidemics were considered visitations from providence.²⁵

Young credited the effective prevention of disease in the war camps with having brought about an "awakening of the public conscience."²⁶ In an address to the legislature near the end of the war, Young clarified his thoughts on the progress of public health:

We have learned nothing of great importance along public-health lines in the present war up to the present time, but what we have gained is the awakening of a very satisfactory proportion of the people to the importance of health-work and to its possibilities. Not in a theoretical direction, but as demonstrated by actual accomplishment.²⁷

This demonstration of public health success was not lost on many of the people on the home front.

However, the war years had a greater impact than simply the high number of enlistment rejects and the application of the 'rules of health' in the war camps. The devastating effects of the influenza epidemic of 1918-1919 brought in tremendous popular demand for a more structured and responsive public health apparatus.²⁸ In addition, the hope that the fight for democracy, 'the war to end all wars' would launched a new and better world, initially helped fuel the social reform movement.²⁹ Armed with this evidence

and enthusiasm, reformers convinced both the state and charitable groups to take up the cause of spreading the gospel of health to the rural areas of Canada. By the close of the war, public health workers and reformers were eager to extend their services to the small towns and rural areas of the country.³⁰ World War I thus became the turning point for public health in rural Canada.

Various government and reform groups took steps immediately after the war to carry their enthusiasm for preventive health care to the outlying regions of the country. Under the leadership of N.W. Rowell, then President of the Privy Council, Parliament created a Federal Department of Health in 1919. This Department was to concern itself with "all matters and questions relating to the promotion or preservation of the health of the people of Canada," without exercising "any jurisdiction or control over any provincial or municipal board of health or other health authority operating under the laws of any province."³¹ The Federal Department of Health was thus created to offer assistance and advice, but not to take the lead and set up national health programs and systems. The provinces were thus given considerable leeway to take individual initiatives in response to the increasingly demand for government involvement in health care.

British Columbia began to set up its own health programs at the close of the war. The Legislature of British Columbia had taken some steps toward better health of the province prior to the war, but various acts such as the Public Health Act of 1893 and the Health Act of 1899 were simply *ad hoc* legislation passed only to insure governmental authority during outbreaks of epidemic disease.³² However, one offshoot of the 1899 Act was the provision it made for the appointment of the first Secretary of the newly created Provincial Board of Health, Dr. C. J. Fagan, the first permanent official to deal with the health problems of the rapidly growing province. While this was a positive step, Dr. Fagan faced a dilemma — how to deliver the public health message to a sparsely populated and rugged province at a minimal cost.³³

Public health measures in British Columbia were rudimentary at best before the advent of the Great War. With almost no support staff to help them carry out their mandate, Dr. Fagan, and later his replacement, Dr. Henry Esson Young, struggled to ensure the health of the growing province. At the start of the Great War the provincial government was delivering public health to British Columbia through only four paid workers. Dr. Fagan, replaced in November 1914 by Dr. H.E. Young, was responsible for all public health activities. Captain F.S. DeGray, appointed in 1903, was holder of a St. John's Ambulance first-aid certificate and as Master Mariner in command of the 65-foot power boat, the *Sanita*, was cannery inspector charged with visiting the canneries and logging camps up and down the 6,000 miles of the province's coastline.³³ Mr. Clive Phillips-Wooley, appointed sanitary inspector in 1896 and backed by the constables of the Provincial Police Force as *ex officio* sanitary inspectors, was assigned the task of ensuring that all health regulations were carried out.³⁴ Finally B.C.'s first school nurse, Miss Blanche Swan, had been appointed in 1913 to visit rural districts, help local doctors with school inspections, educate teachers in public health, write annual reports, and generally deal with all the health and hygiene problems of children in British Columbia.³⁵ Therefore, prior to the First World War, the government entrusted the safekeeping of the public health of the rugged and isolated province to these four overworked representatives.

With the new awakening of the "public conscience" as a result of the Great War, the Liberal reform government, elected in 1916, wanted to take new and substantial action to expand and institutionalize this rudimentary government involvement in public health in the province.³⁶ However, money was a concern and geography a problem. The scattered population would require an extensive bureaucracy, not yet an integral part of post-war provincial governments, while the post-war reconstruction was financially demanding and a burden to the province. As Provincial Officer of Health, Young, former Minister of

Education with McBride's Conservative government, stated after the war, "unfortunately, we were not able financially to carry on the work as quickly as we desired."³⁷

The government thus needed help to defray the expenses demanded by the creation of an extensive public health program and were forced to rely on voluntary organizations. Just as it had done during the war, Victoria turned to women's groups to provide funding and support. Organizations such as the Red Cross, the local Women's Institutes, and the Imperial Order of the Daughters of the Empire (I.O.D.E.) were critical assistants in the government's plan to deliver the public health message to rural British Columbia. As Young remarked in 1919:

I have recognized that the success of this movement would depend entirely upon the continued interest of the women, and I felt that the best means of reaching the people of British Columbia was through the Women's Institutes.³⁸

He captured the degree of the government's early reliance on the Women's Institutes when, in 1920, he stated that:

I look upon the [Women's] Institutes as one of the greatest agents for good as between the Government and the people that there is in existence. This is an organized society now, well established, with definite objects and aims, and as a going concern it can use machinery to facilitate the work of the Department in respect to health matters in the Province, and more particularly in reference to the rising generation.³⁹

Relying on these women's institutes, the government had an extensive, unpaid bureaucracy already in place. All it needed to carry out its public health agenda were highly trained workers who could be trusted to become the 'hands of the state.'

In response to government need and encouragement, women's organizations, which had expanded and entrenched their infrastructure to help with the war effort, were well prepared to take on new worthwhile tasks in the 1920s and beyond.⁴⁰ The women involved in the Women's Institutes, I.O.D.E. and the local councils were urging that some steps should be taken "as they are very anxious indeed to co-operate with the [Health] Department in anything for the welfare of the rising generation."⁴¹

Governments handicapped by slim purses and voluntary organizations eager for reform together looked for solutions — generalized public health nurses appeared to be the answers to their prayers. In her annual reports during the war, the first provincial school nurse, Blanche Swan had stressed the need for nurses throughout the province in all local districts.⁴² Such professionals filled the state's requirements for a cheap work-force: one generalized nurse could be trained to replace the plethora of specialized nurses employed in the city. Also, because of the perceived obedient and philanthropic nature of women, the government expected that nurses would not require expensive supervision or expect significantly high salaries.

Such women also satisfied the aims of the reformers. To the reformers, public health nurses would carry the gospel of good health, which would simultaneously purify and uplift. They could find solace in that the roles and duties of nurses were very similar to the ideal roles and duties of wives and mothers.⁴³ "The 'ideal lady' transplanted from home to hospital was to show wifely obedience to the doctor, motherly self-devotion to the patient and a firm mistress/servant discipline to those below the rung of nurse."⁴⁴ She would not only represent the reformers' middle-class ideals, but as a woman she might gain acceptance where male experts/intruders could not.⁴⁵ As Toronto's first school nurse, Lina Rogers explained, women were better equipped to educate mothers and children:

If she comes as one wielding authority that must be obeyed, she will always fail to gain the best cooperation, although she may gain her point.... Her great weapons of attack will be unvarying courtesy, amiability, persistency and child love.⁴⁶

The reformers thus saw in the public health nurse, the perfect reformer — educated, middle class, Anglo-Saxon, and female. Thus the public health nurse was to become both the 'hand of the state' and the front line agent of reform.

This coalescing of aims and energy at the end of war marked a new era. As Young declared in 1919:

We are at the beginning of an era where a great advance will be made by following up the impression that has been made. Health authorities can only go just a little bit faster than the public will admit, but there has been a reversal, and the public are now demanding that they shall be told what to do, and this opens up the opportunity for the public-health nurse.⁴⁷

However, there was a problem — there was a shortage of qualified nurses and there was yet no such thing as a nurse specifically trained in public health in Canada.

To solve this problem and symbolically launch the beginning of this new era, the first public health nursing diploma program in the British Empire was initiated under the encouragement and directorship of Dr. Henry Esson Young at the University of British Columbia in 1919.⁴⁸ By 1919, the Department of Nursing and Public Health was established on the old Fairview Campus of the University of British Columbia. Only women who had completed a three-year hospital training program, and were certified register nurses, were admitted into the diploma program. Monica Green explained how the public health nursing diploma program worked:

The program was fourteen weeks when it started and later was extended to a full academic year. Lectures were on the campus, practice was arranged in selected areas and field trips to appropriate places were arranged as part of the learning experiences.⁴⁹

The first degree program in nursing, also launched in 1919, operated very similarly except that no prior nursing training was required. In consultation with Ethel Johns, the first director of Nursing at U.B.C., new students were admitted to a five year degree-granting program in nursing but were required to choose a specialty early in their program — either administration and teaching or public health.⁵⁰ Like the diploma students, the academic work of degree students was also supplemented with practical training. The first class graduated with diplomas in 1920, prepared to work in the community setting.

While the state and the reformers both advocated the employment of public health nurses in the rural setting, nursing organization leaders and 'rank and file' nurses were also eager proponents of the creation of a practice field in public health immediately after the

war. Nursing organizations perceived that the greater educational requirements of public health and the relatively high 'professional' position enjoyed by public health nurses in the local community, would be a positive step toward solving some of the problems of their vocation. Suffering from low wages, long hours, poor working conditions and a general lack of respect,⁵¹ nurses clung to the hope that improved status would follow from professionalization as it had for lawyers and doctors.

With the passage in 1917 of Bill 68, *An Act Respecting the Profession of Nursing*, after a decade of setbacks,⁵² the newly formed Graduate Nurses Association of British Columbia (GNABC) set out to consolidate its gains and entrench professional status. The GNABC saw the opening of a practice field in public health nursing as a chance for occupational advancement. It jumped at the opportunity to further its choice of professionalism as an occupational strategy.⁵³ The extra training required for public health offered a chance to raise the educational levels of nurses and thus raise their status.⁵⁴ In the 1920s and 1930s public health nurses emerged as an elite corps, distinguished from their lesser educated cousins in private-duty and hospital nursing.

The practice field of public health nursing also offered a great deal to its new recruits. Public health work offered great opportunities for personal satisfaction, adventure and independence.⁵⁵ Although some hospital and private-duty nurses denigrated public health nursing as something less than *real* nursing because of the latter's lack of 'hands-on' primary care,⁵⁶ it attracted enthusiastic, career-oriented women. The move from the strict confines of the hospital or private home held many rewards and opportunities for those choosing public health, among them a life-long career and a sense of achievement as a part of the emerging social reform movement. Although early pioneer public health nurses undoubtedly faced hardships and loneliness, and the employment rarely met all their expectations, the benefits *represented* the ultimate embodiment of the 'new woman' of the

post-war era and offered women the image of an unconstrained, thoroughly 'modern,' life.⁵⁷

In accord with the government, the reformers, and the nurses themselves, the many recipients of the nurses' services — mainly women and children — accepted and even welcomed the idea of a public health nursing program. To others, the nurse could be seen as meddlesome as she also had a moral message to deliver on how to live a better life that was not always completely palatable to her clients.⁵⁸ However, rural women and children did not have to totally accept her ideas. They saw the nurse as a person whose ideas could be selectively absorbed. More importantly than her moral message, the public health nurse offered the new scientific knowledge and much needed advice on how to stay healthy that was so desperately needed. Regardless of her meddlesome nature, to the woman isolated in the rural areas of the province, far from other women and far from medical advice, the public health nurse thus could be seen as a saviour. Often the public health nurse's clients could simply take what they wanted from her, while ignoring the rest.⁵⁸

As the goals of the state, the reformers, the clients, the nursing organizations and the nurses themselves all intersected, the nurse was promoted to the vanguard of public health reform. An image therefore emerges of post-war health reform west of the Rockies — an image of a uniformed public health nurse carrying a baby scale and a medical bag, stepping out of her Ford and walking up to a front porch in the backwoods. Her car symbolized both her new post-suffrage female independence and the end of a two-tiered (rural/urban) medical system. Her smart blue and white uniform symbolized her professional status and her separation from her all-white garbed occupational cousins in hospitals and in private-duty. Most important were her scale and medical bag. Her scale was more than just a representation of the mysticism and newly placed faith in science, and her bag more than a badge of office. They were a promise to the mother behind the door — a promise that science could now help, measure and ultimately reward good mothering.

With the promise of the gift of health science, the rural woman behind the door voluntarily opened her home simultaneously to a middle-class intruder and the new age of social reform.

The first enthusiastic graduates of U.B.C.'s public health nursing diploma were quickly snapped up and set to work in 1920 in an effort to bring this plan for a new age to fruition. The Rockefeller Foundation and the Red Cross, together with many local philanthropic organizations and a standardized provincial grant, provided the financing necessary to set up and maintain British Columbia's public health nursing service. Local public health committees were created that saw to fund-raising, and administration of the local public health program.⁵⁹ Since there was no standardization of these committees, every community developed a slightly different approach.⁶⁰ For every nurse employed, the Province supplied a grant equal to the grant received by local school boards for each teacher employed, but the local committees controlled the finances and were thus in control in the local public health nursing program. However, in no case did they ever call for the removal of any public health nurse assigned to them by the Provincial Board of Health. As Young explained: "It is pleasing to note that in none of the places they were sent has there been a request for a change, nor has the Department found cause to remove any particular nurse."⁶¹ With every new graduating class, more areas of British Columbia were granted public health nurses. In addition to opening more areas, the service grew from 'single nurse districts', to health centres that employed more than one nurse, to a few health units where several nurses worked in co-operation with a full-time Medical Health Officer. In the more densely populated areas, especially near the capital, health centres were created. These centres employed a group of public health nurses, rather than a single nurse. The first health centre opened in Saanich in 1919.⁶² Even in these multiple nurse centres, the nurses were all of the same rank, as a hierarchy was not developed until the first senior nurse was appointed until 1944 and the second in 1948.⁶³ Usually, the public health

nurses simply divided the area into smaller, approximately equal, districts. The twenties also saw the creation of the first health units which simply entailed the replacement of a health centre's part-time local doctor with a full-time Medical Health Officer. Generally, British Columbia's public health nursing service expanded steadily through the 1920s as quickly as U.B.C. could train qualified public health nurses.

In the next decade, in spite of the severe economic situation, British Columbia's public health nursing service continued on a course of steady expansion. Unlike hospital and private-duty nursing, public health nursing did not suffer an employment crisis in the Depression.⁶⁴ During the Thirties, people could not afford doctors, private-duty nurses or other medical services, and it was the government-employed public health nurses who stepped in and provided primary medical care and medical counselling, acting as a liaison between the people and the doctors. In spite of the poor economic conditions, public health nursing services continued to expand throughout the Thirties "as the value of their work was being recognized by more and more communities."⁶⁵ Permanent Medical Health Officers were even hired during the Depression and three full-time health units created — North Vancouver, Fraser Valley and South Okanagan. For British Columbia's public health nursing service, the Depression passed by almost uneventfully, with public health nurses continuing along the same course that was set for them after WWI.⁶⁶

With nurses' well documented involvement overseas, the Second World War is usually seen by historians and nurses as a major turning point for nursing. However, while the immediate outbreak of war did add some responsibilities, it did not substantially change life for B.C.'s public health nurses. As more and more physicians went overseas, public health nurses' lives became more hectic as they were often left alone to staff the 'home front.' As a result, some areas of the province were temporarily short staffed and their nurses overworked, with Abbotsford/Matsqui's service even being suspended for three months until replacements were found.⁶⁷ With the shortage of doctors, public health

nurses were also handed one extra duty during the war. They began to do immunizations and this practice was to continue after the war.⁶⁸ However, aside from these few problems, the work of these nurses remained much the same while the province's public health nursing service was generally maintained and even expanded. Throughout the war, new nurses continued to be appointed, with the opening of twenty-five new areas. (See Appendix A — "First Appointments as Public Health Nurses to New Districts") Public health nursing also did not undergo a great deal of change during the war as public health nurses were expected to remain at home to help the civilian population. Unlike hospital and private-duty nurses, recruiting officers gave public health nurses a very low priority, so few made it into military service.

With the conclusion of the war, the province was ready for change. Public health nursing districts had been established throughout the province, encompassing ninety percent of the population. However, there still remained many rural areas outside established districts, with only six full-fledged health units outside the metropolitan Vancouver area. The reorganization of the school districts provided the new Ministry of Health and Welfare with the opportunity to reorganize and expand the public health nursing service as well. Some of the city school districts were extended into the surrounding rural communities which had not received public health nursing services while the health department decided the time was opportune for a radical revision of public health nursing districts to coincide with the new school districts. With these changes in organization came changes in the nurses' status. Public health nurses became civil servants and, while they received the accompanying rise in benefits and pay, they lost some of their individualism and independence as local practitioners to an ever-expanding bureaucracy. The voluntary organizations which the government had used to spread the message of health were sidelined as the government dispensed with the official role of the local health committees. Centralization, clerical support, a virtual explosion of building construction, and the

extension of services completed the government's reorganization of public health. All of these changes provided the groundwork for a new era in public health nursing in British Columbia.

In the years 1919 to 1946, it is clear that there was steady expansion of the overall service to more parts of the province. In addition to opening more areas, the service to several communities grew from a single nurse, to a few health centres or health units, each with several nurses. The public health nursing service, originating on Vancouver Island, fanned northeastwards to the rest of the Province like ripples in a pond. As the Saanich Health Centre was being stepped up into the a full-fledged Health Unit in 1927, only seven other areas had even been granted their first nurse.⁶⁹ Many of these isolated areas had to wait until the next 'ripple' reached them before their single nurse district was expanded into a health centre and a further 'fan' of single nurse districts were granted to even more northern and outlying regions. The stage of development of any given community's public health nursing service was thus dependant on both time and place.

While the province's public health nursing service continued to grow, expansion was not change. During the period 1919 to 1946, similarity rather than change characterized British Columbia's public health program. There were no substantial changes in funding or organizing systems, few dramatic technological changes in the nurses' work, and, with the sole exception of giving injections during the war, no sizable shifts in their responsibilities. All of these changes were to wait until the end of the Second World War and the frenzy of activity following post-war reconstruction.

While all these groups — the government, the reformers, the nursing organizations, and the nurses — combined their efforts in the new age of social reform immediately after the war to transport the public health nurse to a front porch in B.C.'s backwoods, this alignment of interests was only temporary. Just as with a rare alignment of the planets, each group had travelled their own route to get to this moment in time and eventually

followed their own paths. After the initial impetus from many groups after World War I, interest in public health reform declined, and public health nursing was no longer a continued focus of attention. Lacking an extensive support structure, adequate funding and further government innovations, the public health nurse was left to struggle on with the burden of all their goals on her shoulders when her supporters' paths eventually diverged. As the times fluctuated around her and interest in her work waned, the public health nurse continued steadily along the same path initially set for her back in 1919.

Notes:

¹Richard Allen, "Social Gospel," *The Canadian Encyclopedia*, p.1717. For a complete discussion of the 'social gospel' see Richard Allen, *The Social Passion: Religion and Social Reform in Canada, 1914-28* (Toronto: University of Toronto Press, 1973). For social reform in B.C., see Jean Barman, "Reform and Its Limits, 1871-1929," *The West Beyond the West: A History of British Columbia*, (Toronto: University of Toronto Press, 1991), pp. 202-235.

²Carl Berger, *A Sense of Power*, (Toronto, University of Toronto Press, 1970); Greg Kealey and Bryan Palmer, *Dreaming of What Might Be: The Knights of Labor in Ontario, 1880-1900* (New York: Cambridge University Press, 1982); Alison Prentice *et al.*, "The 'woman movement,'" *Canadian Women: A History*, (Toronto: Harcourt Brace Jovanovich, 1988), pp.169-188.

³Richard Allen, *The Social Passion...*; Carol Bacchi, *Liberation Deferred: The Ideas of English-Canadian Suffragists, 1877-1918*. (Toronto: University of Toronto Press, 1983); Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1976).

⁴Sutherland, *Children in English-Canadian Society*. See also Ramsay Cook, *The Regenerators* (Toronto: University of Toronto Press, 1985).

⁵See Charles-Edward Amory Winslow, *The Conquest of Epidemic Disease* (Princeton: Princeton University Press, 1943).

⁶Among other things, the germ theory of disease proved to the middle class that their status alone would not protect them from disease.

⁷George Rosen, *A History of Public Health* (New York: MD Publications, 1958), pp.310 & 314.

⁸Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," *A Not Unreasonable Claim: Women and Reform in Canada 1880s-1920s* (Toronto: Women's Educational Press, 1979), pp.131-133; Sutherland, *Children in English-Canadian Society*, p.57.

⁹Canada had one of the highest infant mortality rates of any industrialized nation. Sutherland, *Children in English-Canadian Society*, pp. 56-57. For example: "Montreal was the most dangerous city in the civilized world to be born in." In Montreal, one out of three babies died in the first year. It had the 2nd highest infant mortality rate in the world, only behind Calcutta. Terry Copp, *The Anatomy of Poverty: The Condition of the Working Class in Montreal, 1897-1929* (Toronto: McClelland and Stewart, 1974), pp.25-26, 93.

¹⁰See both Winslow and Rosen.

¹¹Richard Allen, "The Social Gospel and the Reform Tradition in Canada, 1890-1928," *The Canadian Historical Review*, Vol.49 no.4 (December, 1968), p. 384.

¹²Henry Esson Young, 1920 *RPBH*, p.A15.

¹³Sutherland, *Children in English-Canadian Society*, p.55

¹⁴*Ibid.*, pp.39-55.

¹⁵*Ibid.*, p.55.

- ¹⁶Alan Brown, "Problems of the Rural Mother in the Feeding of her Children, *PHJ* (July 1918), p.297.
- ¹⁷Nellie McClung, *In Times Like These*, with Introduction by Veronica Strong-Boag (Toronto: University of Toronto Press), pp.110 & 118.
- ¹⁸Brown, as quoted by Sutherland, *Children in English-Canadian Society*, p.55.
- ¹⁹See also Jessie Forshaw, "How Child Welfare Work Can be Assisted in the Rural Districts of British Columbia," *PHJ* (June, 1921), pp.283-288; F.C. Middleton, "The Nursing, Medical and Hospital Problem in the Rural West, *PHJ* (July, 1919), pp.297-308; See Sutherland, *Children in English-Canadian Society*, p.55
- ²⁰George Rosen suggests that in the United States, the rejection rate was as high as one third, see Rosen, *A History of Public Health*, p. 350.
- ²¹Monica M. Green, *Through the Years with Public Health Nursing: A History of Public Health Nursing in the Provincial Government Jurisdiction British Columbia*. (Ottawa: Canadian Public Health Association, 1983), p.8.
- ²²Young, 1919 *RPBH.*, p.B16.
- ²³This change in image is occurring at the same time as the rural-urban population split turns to an urban majority in the 1921 census.
- ²⁴British Columbia, Provincial Board of Health, *Annual Report* (July 31, 1918), pp. A5-A6.
- ²⁵Young, address to the Canadian Public Health Association (1928) as quoted by Green, p.8.
- ²⁶*Ibid.*, p.8.
- ²⁷Young, 1918 *RPBH.*, p.A7.
- ²⁸Margaret W. Andrews, "Epidemic and Public Health: Influenza in Vancouver, 1918-1919," *BC Studies*. No. 34, Summer 1977.
- ²⁹John Herd Thompson, *Harvests of War: The Prairie West 1914-1918* (Toronto: McClelland and Stewart, 1978).
- ³⁰Sutherland, *Children in English-Canadian Society*, p.70.
- ³¹The Federal Act responsible for the creation of the Department of Nation Health, as quoted by R.D. Defries, ed. *The Development of Public Health in Canada* (Toronto: University of Toronto Press, 1940), p.viii.
- ³²With amendments in 1901, 1904, 1906, 1911 and 1915. J.T. Marshall, "Public Health in British Columbia, *The Development of Public Health in Canada*, R.D. Defries, ed. (Toronto: University of Toronto Press, 1940), pp.101-105.
- ³³Marshall, p. 106.
- ³⁴*Ibid.*, p. 102 and p. 106.
- ³⁵Green, pp. 6-7.
- ³⁶Robin Fisher, *Duff Pattullo of British Columbia* (Toronto: University of Toronto Press, 1991), p.130.
- ³⁷Young, *PBH, Annual Report* (July 31, 1918), p. A6.
- ³⁸Young, 1919 *RPBH*, p.B7.
- ³⁹Young, 1920 *RPBH*, p.A15.
- ⁴⁰Ceta Ramkhalawansingh, "Women During the Great War," in *Women at Work in Ontario* (Toronto: Women's Press, 1974), pp.285-286.
- ⁴¹Young, 1919 *RPBH*, p.A20.
- ⁴²Green, pp. 6-7.
- ⁴³Strong-Boag, *The Parliament of Women* (Ottawa: National Museum of Man, 1976), p.235.
- ⁴⁴Judy Coburn, "'I See and Am Silent': A Short History of Nursing in Ontario," *Women At Work in Ontario* (Toronto: Women's Press, 1974), p.139.
- ⁴⁵A woman might accept another woman's intervention more readily while her husband might not have allowed a man to interfere and 'educate' his wife.
- ⁴⁶Lina Rogers Struthers, *The School Nurse: A Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease Among School Children* (New York: G.P. Putman's Sons, 1917), as quoted by Dehli, p.251.
- ⁴⁷Young, 1919 *RPBH.*, p.B7.

⁴⁸Green, p.9.

⁴⁹*Ibid.*, p.9.

⁵⁰Beatrice Wood, as quoted by Laura Brown, "The Way It Was," *Nursing BC* (August 1991), p.35.

⁵¹Nora Kelly, *Quest for a Profession: The History of the Vancouver General Hospital School of Nursing* (Vancouver: Evergreen Press Ltd., 1973), p.7.

⁵²The passage of the nursing bill came only five days after the new Liberal government granted the women of British Columbia suffrage and the right to hold office, on April 10th, 1917. See Catherine L. Cleverdon, *The Woman Suffrage Movement in Canada*, with introduction by Ramsay Cook, (Toronto: University of Toronto Press, 1974), p.100; Jo Anne Whittaker, "The Search for Legitimacy: Nurses' Registration in British Columbia, 1913-1935," In Barbara K. Latham and Roberta J. Pazdro eds. *Not Just Pin Money: Selected Essays on the History of Women's Work in British Columbia* (Victoria: Camosun College, 1984), pp.315-316.

⁵³For a thorough examination of the fight for professional status in B.C., see Whittaker.

⁵⁴Barbara Melosh, "*The Physician's Hand*": *Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982).

⁵⁵This chance for independence and the elitist strategies of professionalization are the aspects of public health nursing commonly emphasized by nursing historians. See Melosh; Kathryn McPherson, *Nurses and Nursing in Early Twentieth-Century Halifax*, M.A. thesis, Dalhousie University, 1982; Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930* (New York: Garland, 1989); and most traditional nursing histories.

⁵⁶Elaine Gray, taken from the transcription of an interview with Susan Riddell on April 13, 1988, p. 13.

⁵⁷Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pittman, 1988).

⁵⁸For a discussion of post-war women's desire for new scientific information and their careful selection from it see Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," *BC Studies* (No. 64, Winter 1984-85).

⁵⁹M. Moss, "Notes for the Guidance of Public Health Nurses," *PHNB* (1928), pp.25-26.

⁶⁰Annie S. Law, "Public Health Nursing in the Peace River and in Cowichan — A Comparison," *PHNB* (1939), pp.9-13.

⁶¹Young, 1937 *RPBH*, p.4.

⁶²Green, p.12.

⁶³*Ibid.*, p.163.

⁶⁴McPherson, "An Occupation in Crisis", *Skilled Service and Women's Work*, pp.93-148.

⁶⁵Green, p. 41.

⁶⁶*Ibid.*, p.46.

⁶⁷Young, 1936 *RPBH*, p.4.

⁶⁸Green, pp.66-67.

⁶⁹*Ibid.*, p.31.

Chapter 2

Front Line Agents of Reform: B.C.'s First Public Health Nurses and Their Work

The uniformed woman on the front porch in the backwoods — the focus of a great number of forces and the vanguard of public health reform — presents a striking, but lifeless image. What was the background and character of this woman and what was the nature of her work? She was from a specific class of society, hired to do a very specific job. Victoria and the reformers wanted an ideal woman to fill their newly created position, one who had to complete a wide variety of tasks in her daily routine. Given the resources and conditions of her jurisdiction, the role of public health nurse required, in fact, more than an ideal woman — but a 'superwoman.'

The requirements for the women who were to deliver the public health message to rural British Columbia were stringent. G.A. Ootmar, Medical Officer of Health for Kelowna City and District, claimed "the type of Public Health Nurse who is well versed in her profession, with energy, tact, and organizing ability, is invaluable as an assistant in the development of any form of public health activity."¹ Over a decade earlier, the new Provincial Officer of Health, Dr. Young had a similar vision of the type of woman who would make the perfect generalized public health nurse. He was interested "in securing a class of young lady who is not only enthusiastic, but is thoroughly competent and well grounded in the policies of modern public-health work."² This ideal was, it seems, realized in his description of Miss Jessie Forshaw, British Columbia's first Provincial public health nurse: "a young lady of exceptional ability, possessing great organizing powers, enthusiastic in her work, and possessing the valuable faculty of being able to impress and enthuse others."³ Jessie Forshaw was the type of young 'lady' and 'new woman' who would save the province from the old evil of ill-health, delivering information on modern scientific health care.

Government officials were not alone in setting high standards for the public health nursing service. Professionals leaders also promoted and shared the image of the public health nurse as a 'superwoman.' The first Director of Nursing at the University of British Columbia, Ethel Johns, captured the hopes of public health nursing leaders with her image of a public health nurse:

[The] public health nurse should ... be young enough to have enthusiasm and old enough to have sense. ... Her mental qualifications should be above average. She is to be a teacher of health, she should therefore possess knowledge of her chosen subject, and she should be capable of imparting that knowledge to others.⁴

With a vanguard of such women, Ethel Johns and other nursing leaders hoped to ensure the respect of their entire profession.

In the minds of her champions, the public health nurse was a missionary with specialized skills. Her task was to convert the people to the gospel of scientific health. The public health nurse was urged to be:

the link between the public-health science and the community. ... The wonderful struggle for the betterment of existence through the healing touch of science in your hands. You are the channel through which the stream flows to the people. You are part of the great sweep of human progress toward a safe and richer life for all mankind.⁵

As a health missionary, British Columbia's public health practitioner would be like the 'lady with the lamp' who had first illuminated the need for modern nursing:

A torch-bearer — a bringer of light to those dark places — that they may rise and go forward safely to a saner, healthier way of living.⁶

However, she was not simply a specially trained 'curer' and 'carer' of the physically ill, but, because of her specialized skills, this public health missionary was also to be an able healer of the morally ill. Olive Gawley, an experienced public health nurse, thus summed up a prospective public health nurse's requirements: she must be "a graduate nurse, who afterwards has a special training in disease and the care of the mentally, physically, and

morally ill.”⁷ With her power of illumination, the public health nurse was to exhort the people to salvation through the message of scientific health.

While there existed a consensus among the champions of public health nursing concerning the qualifications and duties of a public health nurse, the nurses themselves carried their own set of expectations about the job. Public health nursing offered recruits a chance at helping shape a new province by participating in the “missionary zeal” of the dynamic social reform movement. Patricia East explains that she went into public health nursing in order to help improve society:

Before I went in training most of my life was spent in outdoor work and as the hours flew by I dreamed many things. One of these was to become a nurse and go about doing good, helping people who were in trouble etc. When our community first had a District Nurse I used to envy her unendingly and think of the wonderful opportunities she had for doing good. As soon as possible I trained at the V.G.H., the Public Health Course at Saanich Health Centre, and came back to my community to do Public Health Nursing.⁸

In public health nursing reform-minded women were offered a chance to help build a better world.

While many women entered public health solely for the purpose of building a better world, others sought fulfillment of other aspirations as well. Women perceived that, unlike hospital and private-duty nursing, public health nursing allowed them to operate within a system of greater flexibility where they would have the independence to make important decisions, based, not simply on set procedure⁹ or senior directives, but on their own intelligence, education, and experience. In 1918, Ethel Johns explained this advantage to a set of public health nursing recruits:

You are not tied to routine duties like your sisters in the hospitals; you are not harassed with 1001 petty interruptions; you have time to think and read and plan, and, above all, you have the opportunity to break new ground; you don't have to patch up other people's mistakes and blunders; you will only have to patch up your own; think of that and be happy.¹⁰

With this independence, public health nurses could escape the confining situation in the hospital or sickroom. Barely more than a new recruit herself, Hetty Fawcett asked:

Who would not prefer work which takes one over such roads surrounded by such scenery with the majestic mountains in the background, and in a new Ford coach into the bargain? Who would not prefer that to standing all day in an operating-room with a temperature of 90° or listening to the groans of sick people?¹¹

Since day-to-day routines often varied widely, one practitioner Laura Jukes indicate this independence and variety required a special type of woman:

Generalized Public Health Nursing covers such a wide area that one hardly knows just where to begin in order to give an idea of the work that is being carried on in a rural district. I think it is because of this huge scope that so many nurses are deserting the hospitals for this broader interest. In no other field of work is a nurse so completely thrown on her own resources.¹²

Dr. Esson Young echoed this belief that public health nurses were to have a wide variety of general skills which emphasized prevention. His "single nurse"¹³ was to be able to deal with everything from tuberculosis and V.D. to child poverty, using the revolutionary health tool applauded by social reformers during the progressive era - education. With its variety, freedom and challenge public health offered more than just the opportunity to spread the gospel of health — it also offered the chance to fulfill women's high career aspirations.

Whatever the expectations on the part of both the nurses and their employers, the question to be answered is whether or not they acquired their ideal. In large measure they seem to have. The formidable Miss Forshaw of Saanich appeared, in fact, representative of her successors. British Columbia's public health nurses basically fit the image assigned to them. Overall, they were young, highly educated, enthusiastic Anglo-Saxon middle-class urban women set on attaining their personal aspirations as well as transforming the world into a healthier, and thus, better place.

With the opening of the first Public Health Nursing diploma program in the Empire at the University of British Columbia in 1919, and later the same year the degree program in nursing, British Columbia's public health nurses were exceptionally well-educated and highly trained. All had received hospital training and were qualified registered nurses. In addition, most had specialized training in public health by completing either a degree or

diploma program. By 1928, it became a condition of employment to have earned at least a public health diploma. This educational standard ensured that public health nurses were not only set apart from their clients, but from other nurses as well.

As an educational elite, it is hardly surprising that public health nurses were not representative of the ethnic and class diversity of the province. The high educational requirements determined that many public health nurses would be of higher social standing than the majority of their clients. Ethel Johns, acknowledging these class distinctions, warned public health nurses about untoward displays of class superiority:

Are you going to put on a haughty air like Lady Mand in the poem and "Slay her with your noble birth?"¹⁴

Indeed, Johns suggested to new public health nurses that it was part of their duty to respond to the social level of the women in the rural community and help raise their understanding:

It would seem necessary on entering your fields to acquaint yourselves with the existing social organizations of every kind in your district, no matter how primitive these may be. They may not be 'high-brow,' but see if you can't raise the intellectual level of the Ladies' Aid from the consideration of such topics as "who burned the hole in the parsonage carpet" to a good discussion on how to feed children properly, or what a measles rash looks like.¹⁵

These high education requirements also entrusted that the vast majority of public health nurses would be Anglo-Saxon. Over 91% of the known public health nurses' names were clearly Anglo-Saxon in origin compared to a province-wide average of about 70% during the inter-war period.¹⁶ This distinct ethnic and social makeup ensured their social separation from many clients.

Often, many public health nurses were also distinct from their rural clients because of their urban background. For some of these young health missionaries, including Laura Jukes, country life presented some unforeseen difficulties:

Since coming to the country (being city-bred) I realize how much it means in the country districts, this washing of hands and taking of baths. In the city all one has to do is turn

on a tap, and presto! lovely hot water flows out merrily, making this part of the toilet a delight. Not so in the rural districts. All water must be carried in from some distance from the house and then heated on the stove, making bathing and washing a very tedious process indeed.¹⁷

Echoing Jukes' remarks, the editorial of the 1930 issue of the *Public Health Nurses' Bulletin*, commented on this issue of many nurses' urban background: "The life of the rural Public Health Nurse is seldom a bed of roses. There are so many disadvantages that those of us, who have been brought up in cities, particularly, find facing us in our isolated tasks."¹⁸ The public health nurse was thus 'a lady' who, although well-schooled in the arts of her vocation and willing to save society, was in most cases separated from her clients and community by her ethnic, class and urban background.

The distinctions between the public health nurse and her clients had far-reaching consequences. Many public health nurses, like Vernon's Elizabeth Martin, were suspicious of the influx of new Canadians or 'foreigners' to the province:

On the whole the Vernon school-children are clean. We have careless families, and these have increased with the large influx of New Canadians, thus adding to our work.¹⁹

Her work within the immigrant community only confirmed her suspicions of Anglo-Saxons' natural superiority and general uncleanliness of 'foreigners.'

While these immigrants presented problems, other nurses commented on their surprising willingness to accept their health message. In Fernie, Winnifred Seymour observed that:

There are a great many foreigners in this district and many of the children suffer from malnourishment, but I find them much more teachable than a majority of the white people.²⁰

Nurses, like P. Charlton, saw this willingness on the part of immigrants as a splendid opportunity to assure and quicken their assimilation:

Quite an influx of foreigners has invaded this district during the past few years. They show a great improvement in every way, especially in regard to cleanliness of person and clothing. The Inspector during his last visit remarked on the change. Surely we are

doing a real service to the country if we can show these new Canadians the way to better citizenship.²¹

While immigrants presented a challenge to the sensibilities of these young women, they also presented excellent opportunities to fulfill their larger mandate of social reform.

While pioneer public health nurses were suspicious of immigrant groups, English-speaking Canadians were not exempt from the nurses' concern. Jean Dunbar was not only surprised to discover that Fernie's so-called 'foreigners' were not as unclean as she thought they would be, but she was also ashamed of the English-speaking working class from which she had clearly expected more:

The majority of the population of the district [Fernie] are miners and of mixed nationalities. It is regrettable to have to state that the foreigners are much cleaner in their homes than a certain class of English-speaking residents.²²

In Nanaimo, Margaret Kerr did not think highly of the spending habits working-class residents — both English-speaking and foreigners alike:

The population of Nanaimo is composed very largely of working-class people. There is a tendency to exaggerate the value of such luxuries as automobiles, moving pictures, etc., among the people. The result is that comparatively few children have anything like the proper amount of milk daily.²³

Middle-class attitudes, from whose ranks most pioneer public health nurses were pulled, shaped the interactions between the nurse and her clients while at the same time fuelling their missionary enthusiasm.

While public health nursing was pre-eminently a missionary enterprise with education and prevention always at the forefront, public health encompassed a wide variety of tasks. The work of British Columbia's generalized public health nurses can be classified into six basic categories — school work, infant and child-welfare, community education (propaganda), clinics, bed-side nursing and social welfare service. In each of these six areas public health nurses continued their agenda of education and prevention with the ultimate goal of creating a better world.

School nursing was the first area to be undertaken and the area that consumed the greatest amount of nursing time as children were considered society's most prized possessions. School children were also practical first targets for reform as schools were the one place where the entire 'rising generation' congregated. The British Columbia government took steps to expand "the good work initiated by the provisions of the 'School Health Inspection Act'"²⁴ of 1911. The Provincial Health Officer foresaw that the correction of childhood defects would have a very visible and measurable result — there would be "a very marked improvement in the present rising generation when they reach maturity."²⁵ A responsible government in tune with reform sentiment understood well that "the child who is physically defective will never grow up into a condition that will enable him to be an asset to the state."²⁶

Although there was a rudimentary pre-war system of school inspections in British Columbia, it did not work efficiently. According to critics, parents were not correcting defects found by local doctors, in their role as Medical Inspectors. Yet the doctor was prohibited by law from making a follow-up visit to the family, "in order to prevent the accusation being made that the Medical Inspector was simply creating work for himself."²⁷ Nurses in contrast, as salaried employees of the state, would be ideal intermediaries to explain the diagnosis and prognosis to the parents of children with defects. They would then be able to refer on-going problems back to higher authorities, the doctors.

Once the shortcomings of school medical inspections were recognized nurses seemed obvious solutions to reformers. Dr. Henry Esson Young first suggested the hiring of nurses in 1918 and elaborated on it in 1919. He claimed that "we have found that it is not that the parents do not wish to follow advice, but that they do not understand, and an explanation from the trained nurse as to the effect of allowing defects to persist will bring about a very much larger percentage of cases being attended to."²⁸ In the first year after the war, only two nurses were appointed for this task, as the university programs had yet to

graduate their first classes of qualified public health nurses for the posts; in 1919, Miss Jessie Forshaw was selected for duty in Saanich and Miss Edna Gray in Keremeos.²⁹ However, once the system of training was established, there was a steady expansion of the service to all parts of the province, so that by the end of the Second World War, 182 nurses³⁰ were providing public health nursing services to ninety percent of British Columbia's population.³¹ However, British Columbia's public health nurses' first role was education inside the home in order to encourage the correction of defects uncovered in school inspections.

While Dr. Young envisioned that one visit by the nurse would result in the immediate remedying of defects, often it did not work out so successfully. Sometimes it was found that a nurse would have to visit a home repeatedly in order to 'convince' the family of the 'wisdom' of correcting the defect: "Every parent is notified of these defects and the correction urged, often necessitating five or six visits by the nurse."³² Dr. David Berman, Medical Health Officer of the newly created Saanich Health Centre, explained the important role played by the nurse in the correction of childhood defects:

Each parent was appraised of defects ... found. Our responsibility did not end with a note sent home, but personal interviews and the *dogged determination* of the School and District Nurses that the child be given fair play has resulted in a wonderful attention and correction of defects which will be shown in the next annual report.³³

While this "dogged determination" could be considered 'educating' the parents inside the home, it could also be considered harassing them into accepting medical treatment for their children.³⁴ Saanich's Ester Naden commented on necessity of repeated school home visits:

Not one visit but two, three, or four may be necessary. Hope for correction of defects should not be given up as long as the child is at school, because sometimes the sixth or seventh visit will accomplish what has been apparently hopeless on former visits.³⁵

Clearly, reforming those who wished to remain 'unreformed' required a tremendous amount of labour, energy and dedication.

School nursing did involve some short-term curative work, but much of this work could be classified as 'stop-gap' measures that helped the children in immediate need. Public health nurses assisted the doctor and performed minor first-aid treatments. Nurses also weighed and measured the children, finding a shockingly high percentages of 'underweights'. As Olive Garrood said, "I was surprised to find that 62 per cent. of the children were underweight. Some as much as 10 and 12 lbs. below normal."³⁶ Almost every school checked by the nurses had high levels of underweights³⁷ until a new standard was introduced in the thirties that defined 'underweight' as more than 10% below the so-called 'normal' weight, rather than the old system of anything under normal being classified as 'underweight'.³⁸ As Nurse Charlton explains, she helped remedy this problem of undernourished children by serving milk:

Malnutrition was one of our greatest problems. ... All sorts of schemes and competitions were tried to better this grave defect, but finally we have found the serving of milk at 10 a.m. to be the best of all. Straws are provided, a fact which seems to make the drinking of milk quite an interesting incident in the day's programme. Children who could not be persuaded to drink milk before now drink it, apparently with enjoyment. Most of the children bring their own milk, but in some of the needy cases it is provided.³⁹

However, this type of 'curative medicine' was not a priority nor did it occupy a great deal of the nurses' time.

Public health nurses were primarily involved with educational and preventative work — they spent most of their time teaching children how to live healthier lives. Nurses taught children personal hygiene by conducting handkerchief and toothbrush drills, clothing demonstrations, and spot 'health chore' checks, not always however, with the desired results. Nurse Campbell recounts how she was not completely successful in drilling the 'health rules' with at least one Kamloops child who learned how to avoid the nurse rather than form good health habits:

A little girl who is especially neat and clean one day informed her mother that she was going to take a holiday from the cleaning business. Her mother was rather astonished and asked the reason. Well, the nurse would not be in their room for a day or two as she had

counted the rooms so she was going to have a rest. Her mother cautioned her and explained that it wasn't specially for the nurse that she formed health habits; but no, off she went. On her return that afternoon she was rather crestfallen. Having forgotten the morning incident, her mother was much surprised, on inquiring what was wrong, when the little one answered: "Mother, you are disgraced for life and I'm disgraced for life, for the nurse did come to our room and brought the doctor with her and he just pointed at my finger-nails."⁴⁰

While, the city-bred nurses' ideas of healthy practices did not always translate to rural reality although some nurses did appreciate the troubles that health chores presented the rural children:

This last summer many wells went dry in this district and it meant walking to one's neighbours, perhaps a quarter of a mile distant, for a very precious bucketful. So you may imagine how very much I appreciate the children's interest and co-operation when, at one particular school, whenever I appear, each child presents a pair of well-scrubbed hands. The teacher tells me ... [I am] responsible for the drying up of the wells.⁴¹

The formation of these health habits, when completely adopted, were thus seen as the children's first step in their lifelong health plan.

The school nurse also gave regular talks to all the children on modern health science, including how the body works, what foods were the most healthy, and how disease spreads.⁴² Not only were these lessons designed to indoctrinate the children, but also the children were hopefully to go home and teach their families. Of course, this was not always good news to their families: "some of the parents have told me of their children refusing to eat fried meats and canned foods because nurse said, 'It was bad for them.'"⁴³ Girls were also enrolled in Little Mothers' League classes so they would not only grow up to be informed in scientific mothering, but they would also be able to care for their younger siblings, and thus pass on their scientific knowledge to their mothers.⁴⁴ Nurse Lucas explains the rationale behind these classes:

As Public Health Nurses, with the inestimable privilege of entering schools and working for and amongst the future citizens, we have an outstanding opportunity of helping conserve the infant-life of our country through the medium of the Little Mothers' League classes; the school is the proper place, the Public Health Nurse the logical teacher.⁴⁵

Through the forum of the classroom, it was hoped that the children would be the first converts to the nurses' scientific message and that they would help spread the 'gospel of health.'

The public health nurses were also engaged in school-related work that bore little resemblance to actual nursing. They conducted investigations as to why children were absent from school, approved free scribblers and pencils for needy children, and interviewed parents. These 'extras' were done as a compromise in order to facilitate actual nursing work that nurses felt was important, but that could otherwise not be done. Nurse Dunbar explains, with the case of Qualicum's Little Mothers' League classes, that taxi service fell within her expanded realm:

[Little Mothers' League] classes are held every Thursday at 3:45 p.m. in the school in the most central district, pupils coming from the other districts. As some of the girls have quite a distance to walk I always try and pick some of them up with the car, but on more than one occasion they have walked all the way. I also try to take them home, though it necessitates several trips.⁴⁶

While the school nurse's work clearly involved some non-educational and non-preventative work, it was still missionary in nature. She was out 'doing good' for the children in her district in any way that she deemed necessary.

While the nurses were able to teach health to children through the schools, soon after rural public health nursing started, it was discovered that there were decided flaws within this system. By dealing exclusively with school-age children, public health nurses were often too late to do their greatest good as many of the defects could not be remedied at such a late age. It was clear that the nurse would have to reach children before they entered school.

The public health nurses' work with pre-school children constituted the second major area of their work — infant and child welfare. However, it was not easy to find pre-school children in the rural communities. Along the same lines, pregnant women were also

hard to find. Public health nurses could only reach pre-school infants by acquiring the names of mothers of newborns from the local Vital Statistics Branch's District Registrar and then visiting these mothers. Nurse Higgs of Saanich explains how the process worked:

A list of the births in the district may be obtained monthly from the District Registrar. Before the infant is a month old the first visit is made. The entrance into a home is comparatively simple, when one wishes to see the "new baby". After the first visit the visits should be a monthly occurrence. It is rarely possible to visit at intervals of a month to the day. How frequently, if six weeks have elapsed since the last visit, we hear, "Why, nurse, I thought you were not going to come any more. It is so long since you were here."⁴⁷

However, problems arose from not registering births soon enough (the parents had thirty days to register their child) and only collecting the names every month. Margaret Griffin explains how she was able to re-establish a mother's breast-milk after three weeks:

Getting the names of all babes registered in our district from the Vital Statistics Department, this is one of the homes I went into. "You have a new baby; I came to see if I could be of any assistance"; and that introduction was sufficient. I found that her milk came in all right, but by the end of a week had apparently all gone again. Her babe was put on canned milk and I didn't reach her until two weeks after she came home, three weeks since breast-feeding had been discontinued. She was so surprised when I told her breast-feeding could be re-established ... A visit daily for a week, and the mother informed me that baby was gaining well.⁴⁸

The 'new baby' thus provided the initial opportunity for the nurse to infiltrate the home and establish what was hoped would be a long-term, educational relationship.

The nurses found it remarkably easy to gain entry into these rural homes. Winifred Seymour of Fernie comments of this acceptance:

I have had great joy out of the kindly and courteous reception I have received from the people of my district while visiting in their homes.⁴⁹

Just asking to see the 'new baby' provided access, as Margaret Griffin explained, but the public health nurse represented more than simply an interested visitor. The baby-scales she carried offered a concrete scientific method of measuring these women's success at mothering. Bombarded with new scientific methods of childcare, the mother of the

interwar period was often very concerned that she was 'doing it right.'⁵⁰ Weight-gain was the only 'sure' way a woman could measure her success as a mother, and as a consequence, Port Alberni's Mary Grierson remembers that "mothers took a keen interest in the growth of their babies."⁵¹ Nurse Claxton of Cowichan explains the power of the baby-scales:

To every home where there is a young baby we have that never-failing "open sesame" - the scales! What mother can resist them?⁵²

Nurse Claxton went on to explain how the scales provided a drawing card at the annual fall fair:

The value of the scales as publicity agent was also brought home to us at the last fall fair in Duncan. We had an exhibit showing the three main branches of our work, and of these there is no doubt that the infant-welfare section proved the chief drawing-card. We had our baby-clinic scales, and a nurse present to weigh babies and give advice on their care to any mother who liked to avail herself of the opportunity, and to learn of our child-welfare service. We found many interested mothers and fathers and took names and addresses of several new babies to be followed up.⁵³

Many mothers later went to baby clinics simply to have their baby weighed. Muriel Upshall concluded that her "well-baby clinic is really a weighing-station."⁵⁴ By offering this measure of mothering and thus the opportunity to reward good mothering, the nurse could gain access to home and hopefully, the confidence of the mother.

Many nurses felt that infant home visiting was successful and regarded it as the most fulfilling aspect of their work. Ladysmith's S. Hewerston recorded why she enjoyed baby visits:

Much pleasure is derived from home-visiting, as this gives the parents an opportunity of asking for advice and discussing the minor defects of any other members of the family.⁵⁵

By following newborn clients monthly until they reached school age, the public health nurse was not only able to stay in contact with almost all of the pre-schoolers in the district, but she was also able to extend her initial welcome and continue to pursue health education within the home.

And then having weighed the baby and discussed its feeding, all sorts of little matters concerning the health of other members of the family may be brought up, and we get a good chance to explain our work and what we aim at doing.⁵⁶

Through the newborn, public health nurses could fulfill one of the most important aspects of their work — the education of all.

While visiting infants every month provided an excellent opportunity for advancing her educational cause, it was not a very efficient use of the nurse's time. Ideally, all the mothers and infants should come to her on a monthly basis to learn the 'rules of health' and apply them to their entire household. Nanaimo's Muriel Upshall explained her infant welfare program's aim:

The ambition is to visit the child as early in life as possible, obtain the mother's interest, and give her an invitation to the well-baby clinic, while probably announcing that tea is served.⁵⁷

The goal of the first baby-visit thus evolved to include an invitation to a clinic.

However, women were naturally reluctant to go to 'clinics' where others might think that their mothering needed help and their baby might be sick or 'defective'. Also with transportation and language difficulties, and generally harried lives, taking time to travel to a clinic was often an onerous, sometimes impossible, task. In order to get the mothers and their children into the clinic voluntarily, the nurses made accommodations. Tea was served to create a social atmosphere, and clinics were carefully re-labeled 'well-baby' clinics in order to remove any stigma and to convey the impression that all those attending were good mothers. Nurse Campbell reported on the relaxed character of her Kamloops clinics:

A very pleasing feature of the work is the well-baby clinic The mothers appear to enjoy coming and meeting each other and comparing notes about their babies, and I believe more than one good friendship has resulted. I also find this a good opportunity for having little chats with the mothers about some of their children who are not of school age.⁵⁸

Nurses in Nanaimo made a grievous error when they underestimated the social element of their clinic. When the cup of tea was cancelled in 1927, one of Nanaimo's public health nurses, Margaret Wilson discovered that:

a very few weeks showed this to be something of importance as it held the group of mothers together and enabled them to meet and talk with each other about their little problems. Many mothers have told how much they appreciate the opportunity thus given them. ⁵⁹

Rural well-baby clinics thus offered more than advice on infant care, they took a step toward creating much needed mutual support groups for rural women. Through the creation of these informal groups and the application of science, public health nurses were able to reassure and reward women for good mothering.

The third area of the public health nursing program was dedicated to community education. Even after working several years in one community, and making significant inroads with the mothers and the school children, public health nurses still often had to win over the rest of the community. In pursuit of this aim, public health nurses were engaged in a wide variety of community educational work — in other words, health propaganda. Nurses were engaged in every form of health advertising available to them. They directed health plays, addressed meetings, wrote articles for the local paper, made health floats for the annual parade and distributed literature from any source they could find. (The federal and provincial governments provided some literature, but the majority came from the Metropolitan Life Insurance Company.) The pre-eminence of this community education can be seen by the emphasis placed by Dr. Young on this aspect of the public health work, especially the distribution of health literature:

This branch of our work we consider the most important and we do not allow any opportunity to pass of holding meetings and distributing literature. We average a distribution of 30,000 pamphlets a month and this is growing each month.⁶⁰

In addition, public health education also entailed adult classes in home nursing and hygiene. Esquimalt's Helen Kelly describes the courses she ran in 1928:

During the past year I have conducted a course of twelve lessons in home-nursing for the Sooke and Otter Point Women's Institutes, jointly, and the ladies who attended the classes took keen interest in them, preparing excellent papers for the final class. Good work can be done along these lines.⁶¹

Margaret Griffen of French Creek explains the "good work" her home nursing classes helped achieve — the prevention of an epidemic:

In this community the parents are very prompt about reporting suspected communicable diseases, however slight they may appear to be. This is such a decided improvement on the old adage, "Let them have it while they are young." One case of scarlet fever in a school-child was immediately reported, diagnosed, and isolated, thereby preventing the appearance of any other cases. I cannot speak too highly of this child's mother for her promptness in reporting, and for the intelligent manner in which she carried out the physician's order. Needless to say, I am very proud that she was a member of one of my home-nursing classes.⁶²

These meetings, classes and the distribution of literature was helping to spread the public health message, but its reception was still limited in scope, still mainly reaching children and their mothers.

The public health nurse went to great lengths to 'popularize' public health in order to make it more acceptable and familiar to the community — especially to the male taxpayer. In Vernon and Esquimalt, the nurses managed to convert May Day into Child Health Day.⁶³ Every fair, exhibition and parade was used as an opportunity to carry the health message wider. In Cowichan the local newspaper reported:

In the hall was placed a neat exhibit arranged by the Health Centre nurses. ... While simple in design, it presented a clear conception of the wide scope of Health Centre work and was intended to correct the idea in the minds of not a few people that the work of the centre is confined to school nursing or some other limited branch of effort.⁶⁴

Public health nurses also regularly attended community functions, addressing a large number of meetings. The rising male attendance at meetings was considered, by Dr. Young, as important evidence for the growing popularity of public health:

There has been a change in the picture, and now we find, in attending meetings, that whereas formerly the audience was made up of women with one or two lone men, now we find at least half of our audiences are men who are becoming increasingly interested in the work and give their time and lend their influence to carrying it on.⁶⁵

Dorothy Priestly reported how the men in Prince Rupert began show interest and then financial support:

The men of the community became interested in our work. They were not to be outdone by the ladies. This I felt was a very encouraging reaction. I was asked to speak to the Rotarians at one of the luncheon meetings and this resulted in the establishment of a very promising dental clinic by them.⁶⁶

Through the popularization of public health, the nurses could win over male tax-payers and ultimately find the support and the funding for greater and more expensive endeavours.

The fourth area of the public health nurses' work included the more costly health clinics. Mass efforts to organize the detection and correction of childhood defects were introduced in the 1920s — notably chest, tonsil, eye and dental clinics. Nurses supervised the travelling X-ray clinics for tuberculosis detection (started in 1924 with donations from the Christmas Seal Organization), and solicited the services of surgeons, oculists, and dentists to set up shop temporary in the local community. In the 1920s tonsil clinics, for example, were very common and popular among nurses and doctors, and were seen as 'cure-alls.' Accounts such as Nurse Charlton's description of Armstrong's 1928 tonsil clinic were echoed throughout the province:

Diseased tonsils have been ... thorns in our flesh. Whether this community is worse than the next for defective throats it is hard to say, but it does seem that there are an incredible number of children with diseased throats. In the last two years seventy-five have had their tonsils removed. ... Last spring we had a tonsil clinic, treating a number of indigent pupils in need of treatment. The cost of the clinic was \$175, which we raised by holding several dances. It was a lot of work, but the improvement in these boys and girls has well repaid us. One little chap was becoming deaf; now he can hear almost normally.⁶⁷

While the mass assembly lines of the chest, tonsil or eye clinics were seen as instrumental in the correction of the defects, the dental clinic was regarded as a panacea for the rising generation. The faith placed in all other clinics paled in comparison to the belief that

healthy teeth would bring an end to childhood illness. The logic of the believers was simple, even if somewhat faulty: if dental problems were corrected, then children would be able to eat better, malnutrition would be eliminated, and children would no longer be as susceptible to illness. Dental clinics were thus the ultimate 'cure-all' and pursued with a vengeance. As dentist, Norman Carter explained:

The pain and trouble, the lost time in the school-room, the impaired digestion and general irritability of the child with toothache, is obvious to you all. The after-effects evidenced in crooked and ineffective teeth, in rheumatism, in heart-troubles, in dental bills for restorative operations, and general susceptibility to infectious diseases are being generally recognized.⁶⁸

While these clinics were obviously curative in nature, they were still clearly within the public health nurses' mandate as reformer and missionary. However, these clinics, with their public and clearly measurable benefits, were only brief events within a nurse's day-to-day routine.

The fifth area of work done by British Columbia's public health nurses was bedside nursing. Even though it was not really part of their job description, public health nurses were sometimes called to do this normal curative nursing work. As Nurse Murray explained in 1926, while out "in that corner of the district" doing a baby-visit, "there is a wound to be dressed. An unfortunate man has badly mangled his hand in some machinery at the mill, and as the doctor lives in a town some 30 miles distant the District Nurse has been instructed to do the dressing."⁶⁹ Kathleen Snowdon sometimes operated as a front-line emergency-care worker when she was forced to use her front lawn as the emergency-ward and her car for an ambulance:

Recently the liquor store opened and we had action almost immediately. I was quite alone in my little cottage one night when I was awakened about 2 a.m. by a loud knocking and a happy but slightly inebriated voice talking to my cat. I slipped on my dressing-gown and opened the door and two very tough-looking individuals came pushing in. They seemed slightly offended at my hesitation in producing a light and proceeded to tell a very long tale about a quarrel. I left them talking and went out to look in the car, and found a young breed very badly stabbed and almost pulseless hæmorrhage. The young dentist is my right-hand man in trouble, so I ran down the street and threw pebbles at his window. He came and gave me help and courage. Fetched the telephone-girl to connect the phone, notified the police, and telephoned Penticton for a doctor. The doctor, arriving at 7 a.m.

found that one thrust had penetrated the lung, only missing the heart by an inch. They sutured and made him safe to move, and I turned my car into an ambulance and took him to hospital — a three-hour drive.⁷⁰

Most public health nurses seemed to resent the time taken up with bed-side nursing. Nurse Claxton of Duncan lamented that:

[The people of the community] do not realize that we might be more consistently busy if we had no bedside-work at all, as then we should be able to arrive at fuller and more regular programme of education work. But the needs of the community in this respect have to be met, and, after all, the bedside visit has its uses from the educational standpoint too.⁷¹

Mary Grierson echoed Claxton's sentiments about the educational aspects that could be derived from bed-side nursing:

This service [bed-side nursing] does give an entry into homes that would not be reached in any other way: also a backing that is sometimes needed.⁷²

Muriel Upshall even went one step further to argue that educational opportunities were enhanced when visiting a sick patient rather than advising a well family, as the nurse's advice is "better received when someone is feeling miserable."⁷³ While this was type of work did not fall within the strict confines of public health and preventive medicine, these nurses found solace in the fact that when called upon to function as generalized medical professionals, they could use it as an opportunity for education.

The final area of B.C.'s public health nurses' work was social welfare service. This area spanned a wide range of activities, from determining which families were needy enough to deserve local charity to relocating families. The nurse was the one person in the community who was given access to homes and she often used this opportunity to gather information concerning the social welfare of families. Saanich's Dorothy Tate was asked by a school principal if a family seeking aid was in fact 'needy':

The principal hands me a note from a parent which reads: "Nora needs a new scribbler and art pencil. Would the school please provide them?" I know the circumstances of the family well enough to know that 15 cents in school supplies means a bottle of milk less at home. Nora will receive a book and pencil.⁷⁴

Nurse McMillan, of Cowichan was asked to make a similar social welfare judgement concerning the gift of a Christmas hamper to a local family. She recounts the event:

The phone again: "Is that one of the nurses? This is Mr. A., of the Christmas Cheer Committee. About that family of Burns with eight children; it has been reported to us that they are always well dressed and really do not need a hamper."

"We are acquainted with the family, Mr. A., and know that the mother makes all the children's clothes from cast-offs from friends. She is a very industrious little body and a hamper would be much appreciated, for they have nothing extra for Christmas."

"Very well, then; we will send them a hamper, for you know best."⁷⁵

With just a few words from the public health nurse, both Nora's family and the Burns family were officially and unquestioningly reclassified as members of the 'deserving' poor.

In the monthly reports, along with recording how many defects were found, and how many handkerchief drills were conducted, the public health nurse was required to record how many social service visits she had made. The numbers compiled in these reports were generally important and useful, but in reference to the number of social service visits, in the words of Heather Kilpatrick, "How little they convey!"⁷⁶ In 1937, trying to explain what the public health nurse really does, Duncan's Heather Kilpatrick explains the story of just one social service visit entry in her monthly report when she made a visit to a Doukhabour family in the middle of the night:

In the wee small hours one October morn she was confronted by two policemen bearing four naked children. It appeared that the parents were suffering from some religious delusion and found it necessary to strip themselves and their family of five children and to take to the woods.⁷⁷

She fed and dressed the children and put them to bed at her home. She then climbed into uniform and started off with two car-loads of police officers to the scene of the "birthday-suit ceremony" in search of the others.

Imagine if you can the feelings of the nurse when, as the cars stopped, the hope "that shooting should not be necessary" was voiced. Then, as the men were disappearing into the surrounding bush, one said: "You won't be afraid to stay alone will you, Nurse?" Imagine the darkness and solitude in the country at 3 a.m.⁷⁸

After much searching, the father, mother, and eldest child were found and the latter two transported back to the Health Centre to join the four younger children. Before going to bed she again set off to the home to gather any available clothes for the morrow. Realizing that the farm was deserted, she rummaged around a bit more until she found and armed herself with some chicken-feed and "sallied forth into the barnyard, calling "Chuch, choock" in the approved fashion."⁷⁹ However she was unable to find the cows, so appealed to a kindly neighbour to take charge. She left for home to care for and keep track of her new large family until they could be transferred to other care. Such events help illustrate that the public health nurse was more than just a nurse — she was a broadly defined community professional whose expertise and privileged information was often called upon by other community members.

On any given day, except Sunday, dawn to dusk the public health nurse could be seen motoring about the countryside. Her days were not neatly divided into the six activities of school-work, infant and child-welfare, community education, clinics, bedside nursing, and social welfare — in practice, there was a considerable amount of blending. For example, while on a baby visit, she could inconspicuously inspect the family for social welfare purposes; while working at school, she could approve scribblers for needy children; or while changing a dressing on an injury, she could hand out health literature. The overall picture of public health nurses' work day was quite complicated and often very busy, and an average day required not only a great deal of energy but also flexibility. (see Appendix B — "A Day in the Life")

Public health nurses were not sent out to British Columbia's rural areas simply to cure the sick; they had a much larger agenda. Public health nurses could be likened to secular nuns — they wanted to do good, for both the community and themselves. They were not just called to their work by God to be a 'bringer of light to those dark places', but as Marta Danylewycz argued for the case of nuns,⁸⁰ their vocation offered a rare chance for

independence and career aspirations. This idea of both the public health nurses' predilection for self-sacrifice and their desire for adventure was well illustrated when Edith E. Gustafson, as a new graduate of U.B.C.'s public health nursing diploma program, who, when asked on her application to the Provincial Public Health Nursing Service where she would prefer to be assigned, simply responded that "I'll go wherever I am most needed."⁸¹

Notes:

- ¹G.A. Ootmar, "Report of Kelowna Health Unit," *RPBH* (1935), p.B12.
- ²Henry Esson Young, 1930-31 *RPBH*, p.P29.
- ³Young, 1919 *RPBH*, p.B7.
- ⁴Ethel Johns, "Ideals of Public Health Nursing", *The Canadian Nurse* (Mar. 1918), p.909.
- ⁵C.E.A. Winslow, "Keeping Out of Ruts," *PHNB* (1926), p.9.
- ⁶Johns, "Ideals of Public Health Nursing", *The Canadian Nurse* (Mar. 1918), p.909.
- ⁷Olive K. Gawley, "Queries and Answers of a Public Health Nurse," *PHNB* (1926), p.7.
- ⁸Patricia East, "School and District Nurse, Keremeos," *PHNB* (1927), p.29.
- ⁹For a detailed description of 'set procedure' see Chapter 5 "Ritual and Resistance: The Content of Nursing Work," in McPherson, *Skilled Service and Women's Work...*, pp.231-293.
- ¹⁰Johns, "Ideals of Public Health Nursing", *The Canadian Nurse* (Mar. 1918), p.911.
- ¹¹Hetty E. Fawcett, "Public-Health Nursing, Maple Ridge and Mission Municipalities," *PHNB* (1930), p.48. When Fawcett wrote this she had only worked six months in the summer.
- ¹²Laura I. Jukes, "Coombs, Hilliers, and Errington," *PHNB* (1927), p.20.
- ¹³Young, as quoted by Green, p.9.
- ¹⁴Johns, "Ideals of Public Health Nursing", *The Canadian Nurse* (Mar. 1918), p.911.
- ¹⁵*Ibid.*, p.910.
- ¹⁶Of the 108 women who contributed to the *Public Health Nurses' Bulletin* in the period 1924-1939, 91% had names of Anglo-Saxon origin, 8% of French origin, and 1% other origin. The province-wide ethnic diversity is taken from Jean Barman, *The West Beyond the West: A History of British Columbia* (Toronto: University of Toronto Press, 1991), p. 363.
- ¹⁷Laura I. Jukes, "Coombs, Hilliers, and Errington," *PHNB* (1927), p.20.
- ¹⁸"A Challenge," editorial, *PHNB* (1930), pp.1-3.
- ¹⁹Elizabeth E. Martin, "School Nursing in the Vernon Consolidated Schools," *PHNB* (1930), p.14.
- ²⁰Winnifred E. Seymour, "School-Work in Fernie," *PHNB* (1928), p.20.
- ²¹P. Charlton, "Health Progress in the Armstrong Schools," *PHNB* (1930), p.11.
- ²²Jean A. Dunbar, "The Public Health Nurse in Fernie," *PHNB* (1927), p.17.
- ²³Margaret E. Kerr, "School Nursing in Nanaimo," *PHNB* (1928), p.9.
- ²⁴Young, 1920 *RPBH*, p.A15.
- ²⁵Young, 1919 *RPBH*, p.B16.
- ²⁶Young, 1922 *RPBH*, p.B14.
- ²⁷Young, 1918 *RPBH*, p.A20.
- ²⁸Young, 1919 *RPBH*, p.B16.
- ²⁹See Appendix A for number of public health nurses.
- ³⁰Canadian Public Health Association, *Report of the Study Committee on Public Health Practice in Canada* (Toronto: Canadian Public Health Association, 1950), p.75
- ³¹Green, p.67.

- ³²D. Berman, 1929-30 *RPBH*, p.R42.
- ³³D. Berman, 1927-28 *RPBH*, p.W22. (emphasis mine)
- ³⁴See Veronica Strong-Boag, "'Wages for Housework': Mothers' Allowances and the Beginnings of Social Security in Canada," *Journal of Canadian Studies* (Spring, 1979), pp.28 & 32; Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920-25," *Canadian Bulletin of Medical History* (Vol 6, 1989), p.118.
- ³⁵Ester Naden, "The Home School Visit, Saanich," *PHNB* (1929), pp.14-16.
- ³⁶Olive Garrood, "Public-Health Work on the Kootenay Lake," *PHNB* (1927), pp.12-13.
- ³⁷See Annual Reports of the Medical Inspector of Schools, in the *Reports of the Provincial Board of Health*, 1919-1946.
- ³⁸Norah E. Armstrong, "Nanaimo Schools," *PHNB* (1930), p.32.
- ³⁹P.A.Charlton, "Progress in Health-Work in Armstrong," *PHNB* (1928), p.6; In Nanaimo, the I.O.D.E. supplied milk to the pupils during morning recess period -Margaret E. Kerr, "School Nursing in Nanaimo," *PHNB* (1928), p.9.
- ⁴⁰Anonymous, as quoted by J. Campbell, "Kamloops," *PHNB* (1926), p.15.
- ⁴¹Laura I. Jukes, "Coombs, Hilliers, and Errington," *PHNB* (1927), p.20.
- ⁴²However, not all that was taught in these health lessons was correctly absorbed. Exams revealed some of the more humorous variations:
- Pasteurized milk is milk that has been very carefully detached from infectious germs.
Pasteurized milk is canned cream.
We have two sets of teeth, temporary and perennial.
We breathe in oxygen in the daytime and breathe out carbon dioxide at night.
Before food can be carried by the blood it must be turned into enamel.
The water that comes on our faces when we run is called inspiration.
- Margaret E. Kerr, "School Nursing in Nanaimo," *PHNB* (1928), p.9.
- ⁴³Olive Garrood, "Public Health in Kamloops," *PHNB* (1930), p.28.
- ⁴⁴For complete discussion of familial resistance to modern lesson taught at school see Barbara Riley, "Six Saucepans to One: Domestic Science vs. the Home in British Columbia 1900-1930," *Not Just Pin Money*, (Victoria: Camosun College, 1984), pp.159-184.
- ⁴⁵C.A.Lucas, "Little Mothers' League Classes as Conducted in Saanich over a Period of Five Years," *PHNB* (1927), p.9.
- ⁴⁶J.A. Dunbar, "Public-Health Work in Qualicum," *PHNB* (1928), p.17.
- ⁴⁷N. Higgs, "Child-Welfare Work in Saanich," *PHNB* (1928), pp.14-15.
- ⁴⁸Margaret M. Griffin, "Breast-feeding for the Infants of Saanich Municipality," *PHNB* (1927), p.27.
- ⁴⁹Winifred E. Seymour, "Public-Health Work in Fernie," *PHNB* (1930), p.9.
- ⁵⁰See Veronica Strong-Boag, "Intruders in the Nursery: Childcare Professionals Reshape Years One to Five, 1920-1940," in Joy Parr, ed. *Childhood and the Family in Canadian History*, (Toronto: McClelland & Stewart, 1982) and *The New Day Recalled Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pittman, 1988); Norah Lewis, "Reducing Maternal Mortality in British Columbia: An Educational Process," *Not Just Pin Money*, eds. Barbara K. Latham and Roberta Pazdro (Victoria: Camosun College, 1984), pp.337-357, and Cythia Abeele.
- ⁵¹Mary Grierson, "Port Alberni," *PHNB* (1930), p.34.
- ⁵²Muriel Claxton, "Cowichan Health Centre," *PHNB* (1929), pp.13-14.
- ⁵³*Ibid.*, pp.13-14.
- ⁵⁴Muriel Upshall, "Public Health in Nanaimo," *PHNB* (1930), p.36.
- ⁵⁵S.A. Hewertson, "Public Health Nursing in Ladysmith," *PHNB* (1926), p.14.
- ⁵⁶Muriel Claxton, "Cowichan Health Centre," *PHNB* (1929), pp.13-14.
- ⁵⁷Muriel Upshall, "Public Health in Nanaimo," *PHNB* (1930), p.35.
- ⁵⁸J. Campbell, "Kamloops," *PHNB* (1926), p.15.
- ⁵⁹Margaret Wilson, "Child-Welfare Activities, Nanaimo," *PHNB* (1927), p.23.
- ⁶⁰Young, 1927-28, *RPBH*, p.W6.
- ⁶¹Helen Kelly, "Esquimalt Rural Nursing Service," *PHNB* (1928), p.12.
- ⁶²Margaret M. Griffen, "French Creek and District," *PHNB* (1931), p.8.

⁶³S. Martin, "School Work in Vernon," *PHNB*, 1928, p.11; Helen Kelly, "Esquimalt Rural Nursing Service," *PHNB* (1928), p.12.

⁶⁴Cowichan *Leader's*, as quoted by *PHNB* (1926), p.15.

⁶⁵Young, 1930, *RPBH*, p.R35.

⁶⁶E. Dorothy Priestly, "The Reaction on the Opening of a New Health Centre," *PHNB* (1939), p.35.

⁶⁷P.A. Charlton, "Progress in Health-Work in Armstrong," *PHNB* (1928), p.6.

⁶⁸Norman R. Carter, "Problems of Mouth Health Among Children in Rural Districts of British Columbia in Relation to the Public Health Nurses," *PHNB* (1926), p.12-13.

⁶⁹H. Murray, "Qualicum and District," *PHNB* (1926), p.11.

⁷⁰Kathleen Snowdon, "Keremeos District," *PHNB* (1928), p.20.

⁷¹Muriel Claxton, "Cowichan Health Centre," *PHNB* (1929), p.13.

⁷²Mary Grierson, "Port Alberni," *PHNB* (1930), p.33.

⁷³Muriel Upshall, "Public Health in Nanaimo," *PHNB* (1930), p.36.

⁷⁴Dorothy Tate, "An Open Letter," *PHNB* (1936), p.43.

⁷⁵I. McMillan, "Day Before Christmas," *PHNB* (1937), p.44.

⁷⁶Heather Kilpatrick, "What Do You Really Do?," *PHNB*, (1937), p.29.

⁷⁷*Ibid.*, p.29.

⁷⁸*Ibid.*, p.30.

⁷⁹*Ibid.*, p.30.

⁸⁰Marta Danylewycz, *Taking the Veil: An Alternative to Marriage, Motherhood, and Spinsterhood in Quebec, 1840-1920* (Toronto: McClelland and Stewart, 1987).

⁸¹Edith E. (Donna) Gustafson, taken from the transcription of an interview with Susan Riddell on Feb. 2, 1988.

Chapter 3

“The Left Undones”: The Disillusionment of B.C.’s Public Health Nurses

I find it [public health nursing] is not quite so simple, and, try as I may, I cannot recognize in myself the District Nurse of my dreams.¹

Patricia East’s confession hints that there was negative side, peppered with disappointments, to pioneer public health nursing in British Columbia. Frances Lyne echoes her colleague’s disillusionment:

Fresh from graduation, I was full of theories and ideas burning for an opportunity to apply them. Soon the chance came to put them to the test, and then it was that the real and practical difficulties presented themselves — difficulties which the enthusiasm of the student had overlooked.²

To be a pioneer implies not only the positive attributes of being first — being able to mold and create, but also its negative attributes — being alone and unaided. Although, the public health nurse clearly saw herself as an agent of reform, and could satisfy career aspirations, she was overworked and over-extended. She was expected to be all things to all people: reformer, accountant, spy, social worker, dental assistant, taxi-driver, ambulance-driver, midwife, surgeon, psychologist, food-bank operator, charity operator, counsellor, tea-party hostess, and friend. Obviously, public health nursing in British Columbia’s rural areas was not as glorious nor as simple as the government and many nurses had thought it would be.

British Columbia’s early rural public health nurses faced a variety of difficulties. As the paths of the government, reformers, and nursing organizations diverged and their support waned, public health nurses were left alone to struggle on under the burden of their goals. Not only did they lack an adequate support system, but they did not always even meet with cooperation. Upon their arrival, they faced opposition ranging from penny-pinching local bureaucrats to tradition-bound residents. In addition, they also faced the

problems of operating in a rough and rugged environment. With unreliable transportation, no running water, heavy snows, and poor roads, simple day-to-day life was fraught with obstacles. Faced with such hindrances and seeing their dreams of building a better world fade, many public health nurses unsurprisingly lost their reforming naïveté and became disillusioned.

The public health nurse was often not readily accepted, even by those who were most likely to have been her allies in the delivery of the health message to the community — doctors. The public health nurse took over some of the territory previously covered by the rural practitioner and she had to be wary lest she intrude on his domain. Ethel Johns warned nurses of the problem:

Without meaning to do so you may offend the village oracles, even (under my breath I say it) the local doctor. He may consider your ideas on infant feeding as a trifle highfalutin. He may even characterize your treasured child welfare ideals as tommyrot, but be patient with him; remember he isn't as young as you are and hasn't had your advantages.³

Dorothy Priestly despairingly reported on the unfavourable reaction of Prince Rupert's doctors to her work. She hypothesized that the doctors' lack of co-operation resulted from ignorance and fear of intrusion into their sphere of influence:

So far nothing has availed to convince our Commissioner that we should have a school doctor to do school medical examinations, nor to convince our medical men that they should co-operate in many other ways; perhaps it is because they were not consulted before the nurse came to the district and that they just still do not understand what her work is. The problem is to make them feel that public health needs them in its work and does not wish to intrude into their sphere.⁴

Dr. Henry Esson Young repeatedly commented in his annual reports on this lack of enthusiasm for public health found among British Columbia's medical men. For example, in 1918 he complained about "the laxity on the part of the medical profession in regard to the provisions of the 'Health Act'" and that "it has been a source of constant anxiety on our part to note that the profession does not seem to recognize that upon them devolves the care of the health of the public at large."⁵ Perhaps, Dorothy Priestly was correct, and that

through a genuine ignorance of public health, many doctors considered the public health nurse competition for precious health dollars.

Even the local doctors who tried to co-operate could inadvertently make the nurses job more difficult. Monica Green, chronicler of public health nursing history in British Columbia and former Director of Public Health Nursing, commented on the system of part-time medical health officers:

Although the system provided for some needed services, particularly in emergency situations, it did not generally work too well as far as conduct of routine work or health planning was concerned. The physicians had little or no training in public health as their interest and education had generally been directed towards the treatment and care of sick people. Patient care naturally came first with the result that planned public health clinics, or school visits with the public health nurse, frequently had to be cancelled because of medical emergencies. Many were too busy to give the time needed to this part of their work which did not particularly interest them. The public health nurses wasted much time waiting for them for clinics, waiting for appointments etc.⁶

Public health nurses were thus among the first campaigners for full-time medical health officers rather than the system of hiring local doctors on a part-time basis.

The local public health committee, that handled many of the business aspects of the public health nursing program often caused a great deal of grief for the public health nurses. Esquimalt’s Helen Kelly remarked, in 1925, that “the first and, I might say, one of the foremost problems that a Public Health Nurse has to face is, strange though it may seem, her committee.”⁷ Prominent community members were often more concerned with the financial rather than missionary dividends of the nursing program. A year after her first complaint about her committee, Kelly added that:

Therefore for the first two of three years after the inauguration of such a service the committee in charge have a hard road to travel, and are often faced with the question, ‘What are we getting for our money?’⁸

For example when Marion Fisher tried to open a dental clinic in Kamloops she found that “unfortunately, a few prominent taxpayers strenuously fought the plan by means of public letters.”⁹

However, the obstacles presented by the community were not just financial. Prominent community members were not always the progressive elements within the community, and their reaction to the public health nurse’s work was sometimes conservative and set on maintaining the status quo:

In one school the nurse was horrified to find on a small bench in the cloak-room a little old bucket containing a small amount of dirty soapy water, evidently used by all the children in which to wash their hands. This was reported to the Board of Trustees and the request made by the Association that the bucket be destroyed and clean bowls and paper towels procured. The Chairman of the Board, an old-timer, with a family nearing middle age themselves, was very indignant. ‘I’ll have you know,’ said he, ‘that my boys washed their hands in that bucket, and what was good enough for my boys is good enough for the others.’ Luckily, however, younger and more progressive men were on this particular Board also, and the old bucket discarded.¹⁰

Such disagreements serve to illustrate that the public health nurse was separated from her clients by her urban, class and ethnic background and offered a service that most people did not understand. Olive Gawley said of the rural public health nurse, “she is an outsider ... whose presence may be resented,”¹¹ and some conservative members of the community, “until they require her service in trouble or illness may consider her upkeep a waste of good money.”¹²

Even if the community no longer considered her a waste of money, many of the public health nurse’s clients resisted her actions. According to Nurse Charlton, after an eye clinic drive in Armstrong, for example:

There are still about ten in the school who are very much in need of glasses, but their parents, although quite able, refuse to stand the expense. They seem to think it just a lot of tomfoolery. Educating these people is one of our greatest trials.¹³

Mothers who would not heed the new science message seemed to create special problems for the nurse:

[Some parents] either through blissful ignorance or because they are so busy — are hard to rouse to a sense of their children’s needs, but the most difficult mother to deal with is the one who is so complacently sure that all she does is right, and that there is no room for improvement either in herself or in her family, in spite of much evidence to the contrary.¹⁴

When Keremeos’s Olive Gawley was asked about this resistance on the part of some mothers, her answer illustrates the same ‘dogged determination’ the public health nurse had earlier displayed when doing school defect visiting. “If mothers are indifferent to nurse’s advice, should visits be continued in that home? - Yes, in a social way, always remembering that, no matter how hard the ground, some seeds will germinate.”¹⁵ It is very likely that these ‘indifferent’ clients saw the public health nurse as a middle-class meddler whose message required careful and selective reception.

While to the rugged and ‘uncivilized’ rural environment held some pleasures for the public health nurses, it often simultaneously made day-to-day activities very difficult. Kootenay Lake’s Olive Garrood recounts some of the country life’s rare pleasures:

Every day the public health nurse may be seen wending her way in the early morning to the landing-stage to board the quaint paddle lakeboats that ply up and down the glorious Kootenay Lake; with its background of snow-clad mountains, some towering 10,000 feet, with the tiny fruit ranches nestling at their feet. Journeying up and down this lake is an ever-changing panorama of beauty and colour, varying from the vivid hues of the sunrise to the delicate pastel shades when the sun dips the western horizon.¹⁶

She also acknowledged that her job required more mundane and strenuous modes of transportation than glamorous paddle-boat rides: “Life is not all travelling with this vista of beauty. It also includes walking many miles daily to the various schools and centres.”¹⁷

Public health nurses were regularly travelled by foot over long distances to make visits. Annie Law, of the Cowichan Lake District, recounts an adventure while travelling in the winter on foot:

A message comes into the nurse. She is wanted up at Yapp Alley ... the name given to a little Finnish settlement situated about 1 1/2 miles up Cowichan Lake from Youbou. There are two ways only to get to Yapp Alley — either by boat up the lake or, and more usually, by walking along the railway. Just now the tracks have been ploughed clear by the train and have a bank of snow from 2 to 4 feet in height on both sides.

The nurse sets out about 3 o’clock in the afternoon ... proceeding up the track the nurse sees the steam from the engine of a train ahead of her and fervently hopes it will stay where it is until she crosses the trestle over the Cottonwood [Creek]. However, it is not to be — down comes the train and she is forced to leave the track and take refuge in the bank of snow. Fortunately it was not very deep — only up to waist. She stands there with snow filling her gum boots and melting clammy down the backs of her legs

while the train lumbers slowly by; then, floundering out of the snow, she sets off once more.

Crossing the trestle in safety, she encounters a further obstacle in the shape of an engine, a snow-plough, and a number of flat cars that are drawn up across the only road to the houses that she wants to reach....

A kindly trainman notices her dilemma. "Want to cross, Miss? Just a minute and we'll couple up and move the cars." He signals to the engineer; the cars are coupled and moved passed. She crosses quickly and goes down the trail to her destination.

Two hours later, her work done she comes back to find the same train drawn up, facing the opposite direction. There is nothing but a bank of snow, 4 feet high, all along her side of the train. The only path is across the track.

"Come through this way, Miss." ... Pushed from behind by a sectionman ... and pulled by the engineer, she reaches the floor and passes through the cab, to be assisted down to the trail on the other side. The sectionman is on his way home also, and ... they walk down the track together...

About a mile further down they come upon a string of ten flat cars. There is no way to go around, so, assisted once more, the nurse scrambles up and they walk upon the top, leaping from car to car. They must hasten now to reach the siding before another train comes. As the train approaches, the last few steps are taken on the run; the train passes, then it is a clear road home. ...

Climbing the stairs to her room, she notices how the light is fading and the stars are beginning to twinkle in the clear sky to the east. Another day is ended — another call has been answered.¹⁸

Like Law, Muriel Claxton of Cecil Lake in Peace River District, also found that transform a simple walk might become an ordeal. Of all the many ways she had travelled to visit a patient, Claxton claimed that "perhaps the most unusually (and undignified) was on my hands and knees."¹⁹ Hearing that there was a sick child on the other side of the lake, Nurse Claxton left her unshod horse at the house she was visiting and proceeded to walk the odd half-mile or so across the ice instead of going 2 or 3 miles around. For some little way out from the shore the ice was comfortably covered with snow, but out in the wind-swept centre it was plain well-polished ice and she found herself "sitting down suddenly every few yards."²⁰ Finally, in desperation, Claxton recounted that "I took to my hands and knees and crawled across the lake nearly to my patient's door."²¹ Whether travelling by dog-sleds, paddle boats, ferries, horseback, snowshoes, walking over rickety bridges, or even crawling, nurses required physical endurance to deliver their message everywhere in their districts.

In addition to physical stamina, the ability to drive and repair a car was also a condition of employment. The advent of the automobile was the technological

advancement that permitted rural nursing in Canada, but it also represented both the emancipation of the rural nurse and her servitude. Nurse Dunbar’s relief of finally receiving a new car, hints at the problems she suffered by her old one:

I have the pleasure of a new Ford coupe, fate having been kind in allowing the old one, which has long ago seen its best days, to be burnt along with a number of other cars in the garage.²²

Nurses’ problems with their cars was anticipated by Ethel Johns and the developers of U.B.C.’s degree and diploma program in nursing. Beatrice Wood, one of the first three women enrolled in the degree program in 1919, remembers her early training: “In the last year of university, we took a course in motor mechanics, learning how to change a spark plug and the like.”²³ Saanich’s Ester Naden’s comments in 1930 illustrates how important the cars were to the nurses and hints that seniority, and its resulting prestige, was rewarded with automobiles:

Our old Ford roadster has been turned in and we now the proud possessors of a 1930 Chevrolet coupé. We also have a 1929 [F]ord touring and an old-style Ford touring popularly known as the “Death-trap,” which, in spite of two fairly serious accidents, has not become permanently disabled. The newest member of our staff looks longingly at the new coupé and wonders if she will ever have a decent car to drive.²⁴

The next year Ester, Naden brought the *Bulletin’s* readers up-to-date on Saanich’s automobile situation:

By the time the Bulletin is printed we hope to have disposed of the last of the Model T Ford cars and to have a coach in its place. This will give us two closed cars and one open model. Car expenses are down somewhat and our committee is finding it cheaper to get a better type of car.²⁵

Kathleen Snowdon of Keremeos recalled that while they had their problems, the old cars were big and adaptable — she routinely converted hers into an ambulance:

A word about the car. It is a Tudor [sic] Ford. The front seat folds down and with an apple-box, plenty of cushions, and a cot mattress a most comfortable bed, on which even an adult may lie at full length, can be made. This is a wonderful advantage and makes the journey more comfortable and safer for the patient.²⁶

Monica Green explained that Bertha Thomson, public health nurse in Keremeos, also found the old cars to have their advantages:

She had been accustomed to fording the Similkameen River in an old beat-up car with a high clearance, and in 1942 when it was finally replaced with a sleek now low-slung model, the smart new car couldn't make it across the river and she had to go the long way around.²⁷

As problematic as these cars were, they were the most vivid symbol of these women's status as 'modern-day' adventuresses.

Cars had given nurses the ability to venture out, but only the most brave were able to tackle B.C.'s primitive inter-war system of roads and highways. The horrors of driving in B.C. did not always result from the condition of the cars, but rather from the roads and the weather. Qualicum's J. Dunbar was much relieved when the winter was finally over:

As I look back on the daily troubles encountered on snow-blocked roads in an old Ford roadster, never knowing the minute the car would be sent skidding into the ditch or over tree-roots into the bush, I heave a sigh of relief that the winter is over and there is the bright spring and summer months to look forward to.²⁸

Peachland's Olive Ings' discovered that just waiting for the end of winter did not always help:

When I first caught sight of the steep snow-clad hills of Peachland I said to myself: "Will I ever screw up nerve enough to climb those hills in a car?" Having just arrived from Vancouver, where I had been accustomed to driving on flat, cement roads, I felt transportation would be one of my main difficulties in a rural district. I soon found that my fears had not been groundless. More than once, when I started out on one of those icy roads, I felt like turning tail. I used to think, "if only the snow would go"; and the next thing I knew I was experiencing the joys of being stuck in the mud.²⁹

But as Kathleen Snowdon explains, when there was an emergency, there was no choice but to brave the weather:

I have again had to turn my car into an ambulance, arriving home on Monday morning at 5:50 a.m. These trips usually mean having to dig out of at least one snow-bank. It is never safe to journey without a shovel. My car and I have braved some very treacherous roads, sometimes seeming almost reckless in the attempt, but we are so far from medical aid and the doctors find the trip so difficult that, when it is at all possible, serious cases must be sent to hospital either by train to Princeton or in my car to Penticton.³⁰

Independence and adventure was often gained at the risk of personal safety. (See Appendix C — “Transportation”).

In addition to its dangers, poor weather also reinforced the isolation and loneliness suffered in rural areas. Fernie’s Jean Dunbar reported that “we have had a very severe winter this year.... It is almost impossible to get about; the snow-plough goes along most of the main streets, but up here where I live the snow is too deep for the horses to get the plough through, so we have men digging a path to the more cleared roads.”³¹ Sent to the remote areas of British Columbia, many nurses were socially, as well as physically isolated. Many nurses found themselves in the situation where they were the only person of their social level in the community. At least Kathleen Snowdon had the local dentist to be her “right-hand man in trouble,”³² but even she despairingly remarked that “we lone nurses in the far-off districts do so desperately need some one to talk ‘shop’ to occasionally.”³³

Being the only professional in the area could not only result in loneliness but also in heavy responsibilities. Public health nurse Olive Gawley explained that this isolation was the reason why the nurse of higher capabilities should be sent to the rural rather than the urban districts:

The nurse with the very best training should be sent to the rural district, as in many cases medical and surgical assistance is scarce and the nurse must take responsibility, owing to lack of adequate transportation and oftentimes poor roads.³⁴

This responsibility often resulted in the nurse being pulled in many directions. In 1925, Edith Walls of Sayward, Vancouver Island,³⁵ described a day that illustrates how the public health nurse’s job description was often enlarged to meet community needs. When she was visiting a neighbour, a message came that a young woman was ill at a camp eight miles away. She left immediately. On the way she was intercepted by the mail carrier who told her that the woman was, in fact, in labour earlier than expected and would not be able

to make it to the Rock Bay Hospital as planned. Nurse Walls went to the home of the expectant mother, and by 2 a.m., for her first time, had helped deliver the family’s first child. After assisting this patient, she was met by another concerned father whose son had cut his foot with an axe. Nurse Walls had to cut it open to remove the foreign particles, clean it out, and suture it up. In two days, she had been a nurse, a midwife, a doctor, and a surgeon.³⁶

In the face of such demands, many nurses became discouraged. This response was anticipated by superiors, who came up with a variety of often inadequate solutions. Dr. Young advised them that:

An interesting book to read, the company of congenial friends, or indulgence in a meritorious picture display may be used as a means of driving away a feeling of discouragement or antagonism. With the mind once more poised the District Nurse can go forth to her work with a different view-point from which to deal with her daily problems.³⁷

While acknowledging the difficulties of their occupation, Young continued to treat nursing as a vocation. He felt that, in addition to the many professional journals that nurses should subscribe to, they also should read books related to public health. However, as one realistic nurse observer pointed out, “very few Public Health Nurses can afford to purchase [reference-books] for themselves.”³⁸ Realizing this difficulty, the Public Health Committee of the British Columbia Graduate Nurses’ Association, in co-operation with the Provincial Library Commission created the “Open Shelf” lending system to help the nurses cope with isolation and loneliness.³⁹ The question nevertheless remains: would “indulgence in a meritorious picture display” or reading *The Land of Health* by Hallock and Winslow or *Healthy Living* by Winslow⁴⁰ really counter the problems suffered by these isolated nurses? While Young recognized the problem and was obviously trying to help, it is doubtful whether these modest measures were either very realistic or useful.

While isolation and loneliness were major obstacles, many nurses refused to give up, convinced that they were on a great mission and that their message was almost magical.

Frances Lyne instructed that “by patience, perseverance, and repetition she must overcome prejudice, ignorance, and dread of the unknown.”⁴¹ As Nurse Murray of Qualicum said, in 1926, about the delicate and sickly baby cared for by a young and inexperienced mother, “the little mite seems to recognize the uniform and manages a sickly smile.”⁴² Little smiles like this were enough for some nurses, but others quit public health for other nursing or marriage, and still others requested transfers to the city or were promoted up into administration. Some nurses, like Laura Jukes of Coombs, Hilliers and Errington coped by using the challenge presented by these difficulties as their *raison d’être* :

And while difficult situations sometimes arise, they are stimulating and serve as an impetus to go on when these difficulties have been met successfully.⁴³

Other nurses just patiently waited and hoped for easier times in the future. For Edith Walls, things eventually did get better:

Time changes all things. It is now four years since I was appointed Health and District Nurse for Sayward, and in place of past opposition and ignorances of my work I now feel that the majority of the residents realize I can be of assistance to them and apply to me for help from time to time.⁴⁴

For others, in contrast, life only seemed to get worse. Expressing the desperation, helplessness and frustration of working in a pioneer area during the depression, Muriel Claxton wrote from Cecil Lake, north of the Peace River in 1935:

Four years of public health work in this new section of the Peace River Block — and what is there to show for it? I’m afraid not very much. When I look around, I wonder what I have been doing! ...

I don’t feel satisfied. And now the time has come to move the outpost farther north across the Beaton River to a still more newly opened-up district, where the settlers are particularly isolated from doctor and hospital by bad hills and lack of roads.

...Regarding the advance of public-health work, I foresee the same obstacles — poverty, indifference, and superstition.

The standard of living over here is decidedly low. I am confronted right away by the problem of over-crowding, lack of right feeding, lack of good water, lack of adequate sanitary arrangements, and most serious of all, lack of desire for better conditions. And I might almost add — lack of time!

They need so much that my little bit of public-health work seems just a “drop in the ocean.”⁴⁵

Still others were able to hope for a better way in a better time. Colwood’s Helen Kelly designed a ‘dream health centre’ where “boys and girls and men and women and babies would come to ‘play’ and learn to be healthy.”⁴⁶ “Where anything even suggestive of sickness is strictly taboo.”⁴⁷ Nanaimo’s A. Verna Beckley, simply asked “May we be granted an increase in staff, and that right early!”⁴⁸ (See Appendix D — “Then and Now”)

In spite of all the pressure placed on each nurse as she was planted alone in an area and then virtually abandoned to deal with all the arising problems herself, some public health nurses were able to hold onto a vision that carried them through. In the words of Public Health Nurse, Jennie Hocking, in Saanich, in 1935:

A SCHOOL NURSE’S DAY DREAM

Miss “S” stepped into her car one day
And sped to the West-side School away.
Her aim to weigh and measure a class
And see if all could the eye-test pass.
The road was clear and the air was great.
Miss “S” she travelled at quite a rate,
Got there at ten forty-six, I’d say—
Recess, and all the children at play.
Thought to herself, while they have their fun
I’ll park out here and enjoy the sun.

Miss “S” was tired and the sun was warm.
Her eyes they closed after one big yawn.
Far in the distance she heard a sound
Like muffled footsteps from all around.
Still nearer and nearer came the tread
So our nurse raised up her drowsy head:
She looked and saw a most wondrous sight.
Thousands of nurses in blue and white.
Behind them stretched for miles and miles
Doctors and dentists, and all with smiles.

They said, “We’ve cars, equipment, and cash.
Tone diagnosis for every rash
Hospitals, clinics, glasses, shoes,
And pasteurized milk for everyone’s use.
A law has been passed and health is free
We’re to hand it out unsparingly.
Let’s now remedy ev’ry defect.
Quarantine even a ‘cold’ suspect.
Our job is to make the whole world well.
When you need our help just ring this bell.”

She woke to find though the bell was gone.
Quite loud in her ears still rang its song:
Playtime was over and school went in,
Miss “S” jumped out with her usual vim:
She weighed and measured and tested eyes,
Thought of her dream with a little sigh.
They needed an army, and she but one,
To see that some healthy work was done;
Though results she got were to be admired,
‘Twas the “left undones” that made her tired.⁴⁹

Notes:

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- ¹Patricia East, “School and District Nurse, Keremeos,” *PHNB* (1927), p.29.
²Frances Lyne, “Theory and Practice,” *PHNB* (1928), p.5.
³Ethel Johns, “Ideals of Public Health Nursing”, *The Canadian Nurse* (Mar. 1918), p.910.
⁴E. Dorothy Priestly, “The Reaction on the Opening of a New Health Centre,” *PHNB* (1939), pp.35-36.
⁵Henry Esson Young, (1918) *RPBH*, p.A6.
⁶Green, pp.30-31.
⁷Helen Kelly, “Problems of the Public Health Nurse,” *PHNB* (1925), p.7.
⁸Helen Kelly, “Esquimalt Rural Nursing Service,” *PHNB* (1926), p.9.
⁹Marion Fisher, “Kamloops,” *PHNB* (1925), p.11.
¹⁰Helen Kelly, “Esquimalt Rural Nursing Service - Report of Progress,” *PHNB* (1927), pp.6-7.
¹¹Olive K. Gawley, “The Public Health Nurse At Keremeos,” *PHNB* (1926), p.6.
¹²*Ibid.*, p.6.
¹³P.A. Charlton, “Progress in Health-Work in Armstrong,” *PHNB* (1928), p.6.
¹⁴Margaret A. Thatcher, “First Impressions of School Nursing — Duncan,” *PHNB* (1928), p.8.
¹⁵Olive K. Gawley, “Queries and Answers of a Public Health Nurse,” *PHNB* (1926), p.8.
¹⁶Olive Garrood, “Public Health Work on the Kootenay Lake,” *PHNB* (1927), p.13.
¹⁷*Ibid.*, p.13.
¹⁸Annie Law, “Just One Call,” *PHNB* (1937), pp.29-30.
¹⁹Muriel Claxton, “Transportation,” *PHNB* (1936), p.9.
²⁰*Ibid.*, p.9.
²¹*Ibid.*, p.9.
²²J.A. Dunbar, “Public-Health Work in Qualicum,” *PHNB* (1928), p.16.
²³Beatrice Wood, as quoted by Laura Brown, “The Way It Was,” *Nursing BC* (August 1991), p.35.
²⁴Ester S. Naden, “The Saanich Health Centre,” *PHNB* (1930), p.10.
²⁵Ester S. Naden, “The Saanich Health Centre,” *PHNB* (1931), p.9.
²⁶Kathleen Snowdon, “Keremeos District,” *PHNB* (1928), p.20.

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- 27Green, pp.57-58.
- 28J.A. Dunbar, “Public-Health Work in Qualicum,” *PHNB* (1928), p.16.
- 29Olive Ings, “First Impressions of Rural Public-Health Nursing,” *PHNB* (1930), p.15.
- 30Kathleen Snowdon, “Keremeos District,” *PHNB* (1928), p.20.
- 31Jean A. Dunbar, “The Public Health Nurse in Fernie,” *PHNB* (1927), p.17.
- 32Kathleen Snowdon, “Keremeos District,” *PHNB* (1928), p.20.
- 33Kathleen Snowden, “Public-Health Nursing In Keremeos,” *PHNB* (1929), p.32.
- 34Olive K. Gawley, “Queries and Answers of a Public Health Nurse,” *PHNB* (1926), p.7.
- 35Situated on the east coast of Vancouver Island, 180 miles from Victoria.
- 36Edith M. Walls, “Pioneer Nursing of Vancouver Island,” *PHNB* (1925), p.5.
- 37Dr. Henry Esson Young, “Editorial,” *PHNB* (1928), p.1.
- 38Isabelle M. Gibb, “Editorial,” *PHNB* (1929), p.1.
- 39*Ibid.*, p.1.
- 40E. Martin, “Vernon,” *PHNB* (1929), pp.21-22.
- 41Frances Lyne, “Theory and Practice,” *PHNB* (1928), p.5.
- 42H. Murray, *PHNB* (1926), p.11.
- 43Laura I. Jukes, “Coombs, Hilliers, and Errington,” *PHNB* (1927), p.20.
- 44Edith M. Walls, “Greetings from Pioneer Sayward,” *PHNB* (1926), p.9.
- 45Muriel Claxton, *PHNB* (1935), p.4.
- 46Helen Kelly, “Colwood,” *PHNB* (1924), p.4.
- 47Helen Kelly, “Esquimalt Rural Nursing Service,” *PHNB* (1926), p. 11.
- 48A. Verna Beckley, “Public Health in Nanaimo,” *PHNB* (1928), p.18.
- 49Jenny Hocking, *PHNB* (1935), p. 3.

Conclusion

During the summer of 1990, in the *Vancouver Sun*, then Social Credit Finance Minister, Mel Couvelier expanded on the British Columbia Provincial government's position during the then current public health nursing strike. Responding to the public health nurses' demands for wage parity with hospital general duty nurses, Couvelier argued that public health nurses certainly do not deserve to be returned to their traditional position at the top of the nursing wage hierarchy, nor even given equal treatment as their lesser-educated hospital counterparts: "A nurse isn't a nurse, isn't a nurse."¹ He claimed that although public health nurses were better educated, their job had inherently less stress than the average hospital general duty nurse, and much less than those nurses in Intensive Care Units or emergency wards. Less stress, he argued, should be represented by less money. The political debate aside, Couvelier's suggestion, as well as other contemporary cost-cutting suggestions such as replacing most public health nurses with lesser trained, health educators, raises important questions about the nature of public health nursing and why it is now seen, by some, as very different than hospital nursing. This thesis both examines public health nursing in a context of social reform and offers a definition of public health nursing that emphasizes prevention, and thus substantiates the differences between the branches of nursing, so carefully alluded to by the finance minister.

Historians have had a great deal of difficulty with the history of public health nursing. When dealt with at all, public health nurses are usually portrayed as either secondary characters or great heroines. Only recently have revisionist histories begun to examine public health nurses as workers and women. American revisionist historians such as Melosh, Reverby and Buhler-Wilkerson, have taken critical steps toward our understanding of nursing, but because of the inherent differences between the Canadian and American medical systems, their models and findings are not directly transferable to the Canadian case. In Canada, there were not three, but four branches of nursing — hospital, private-duty, visiting and public health. McPherson, having directly transferred the

American models to Canada, examined visiting nurses under the guise of public health nursing and has therefore obscured public health's preventive nature.

When historians have acknowledged the distinct nature of public health nursing, their work has concentrated on Ontario's public health systems and many of their conclusions do not apply to British Columbia. In British Columbia, there is not as large a gap between ideology and experience as that reported by Abee and Stuart in Ontario. The despondency suffered by Ontario's public health nurses over the complete demise of the rural public health program was far more drastic than the disillusionment suffered by British Columbia's public health nurses. This was largely due to the differing nature of the funding provided for public health programs in the two provinces. In British Columbia, local communities received provincial grants to help with the cost of maintaining a public health nurse whereas in Ontario, the communities were expected to shoulder this cost entirely on their own. Also, the considerable influence of Henry Esson Young on British Columbia's public health system was probably one reason for the differences of the relative success of the two programs, but more study needs to be done on his life to determine the extent of his personal impact. These differences resulted in the steady expansion of the public health services in rural British Columbia and the collapse of rural public health in Ontario.

Using a definition and periodization that reflects the distinct nature of the profession, this thesis examines the history of public health nursing in British Columbia. In Canada, public health emerged as a fourth branch of nursing. Less tied than other branches of nursing to the developments of curative medicine or the growth of hospitals, public health nursing can best be understood as a critical component of the social gospel and the 'missionary zeal' that characterized middle-class activism during the early twentieth century. Placing public health nursing within a social reform context, this thesis reveals that the reform impulse was carried on throughout the interwar period in the duties, expectations and lives of pioneer public health nurses in rural British Columbia. Relying on the voices of these pioneering women, as heard through their reports, as well as a

variety of other sources, this thesis illuminates an important area of women's paid work and British Columbia's rural past.

The creation of a public health nursing service in rural British Columbia was the result of a combination of forces. The reformers' concerns about the degradation of modern society, coupled with the effects of the First World War, had created a climate conducive to public health reform after the war. The Liberal government of the day was elected on a platform of reform promises and set out in 1919 to create a public health nursing service for rural British Columbia. The newly created Graduate Nurses' Association of British Columbia was eager to entrench its demand for higher educational standards for nurses, and the new diploma and degree programs promised just that. Many 'rank and file' nurses were also eager to embark on the adventure promised by public health. All of these interest groups combined to promote the position of the public health nurse to the vanguard of public health reform in British Columbia that remained unmodified until the conclusion of the Second World War.

British Columbia's public health nurses thus embarked on this journey of adventure. Working in rural B.C. granted these women a tremendous amount of freedom from the constraints of the hospital or private home. They were free to exercise the benefits of their education without having to constantly answer to doctors and other supervisors. In the small communities where they worked, the public health nurses were granted quite high regard and used this position to further advance the ideas of public health reform entrusted to them by their supporters. Although their work covered a wide variety of tasks, ever present was their emphasis on prevention and reform — they were truly attempting to help build a better world by first building a better B.C..

However, the road to better health for British Columbians was not a smooth one for the nurses. The independence they were granted by the small communities, also ensured their isolation and loneliness. The autonomy they were awarded by being the only professional in the area, also yielded overwork. These problems, coupled with the harsh

environment in rural British Columbia, for some, made pioneer public health nursing a thankless task. A vast array of difficulties — from penny-pinching, local bureaucrats to death-defying mountain roads — faced these pioneering women. Many became discouraged and disillusioned, but these women were unusual, and most managed to cope by holding on to a vision of a healthy future society that carried them through. Public health nurses were not simply providing short-term caring and curing for the poor, they had a larger, long-term purpose. They were sent out to the remote parts of the province on a mission — a mission to permanently cure society's ills.

Notes:

¹Mel Couvelier, "Psychiatric nurses' goal unrealistic, minister hints," as quoted by Jeff Buttle, *Vancouver Sun* (July 9, 1990), p.A8.

Appendices

Appendix A

First Appointments as Public Health Nurses to New Districts by Year

1913	Victoria.....	Blanche Swan
1916	Victoria.....	M. Locke
1918	Victoria.....	Gregg
1919	Saanich Health Centre.....	E. Foreshaw
	Keremeos.....	Edna Gray
1920	Cowichan Health Centre.....	Bertha E. Hall
	(Duncan)	
	Esquimalt Rural (Langford).....	Helen Kelly
	Nanaimo City.....	J.H. Woods
1922	Kamloops.....	Thom
	Penticton.....	Frances Whittaker
	Kelowna.....	Janet Hardy
1923	Nanaimo Rural.....	Amy Lee
	Sayward.....	Edith Walls
1924	Vernon.....	Jean Dunbar
	Armstrong and Spullumcheen.....	A.L. Mercer
	Fernie.....	E.M. Wade
	Ladysmith.....	M.A. Davie
1925	Keremeos (reorganized).....	Olive Gawley
1926	Qualicum and District.....	H. Murray
1927	Kamloops (reorganized).....	Olive Garrood
1928	Port Alberni.....	Mary Grierson
	Kelowna Rural.....	Anne F. Grindon
	Oliver.....	M.A. Twiddy
	Chilliwack Municipality.....	Winifred Green
1929	Maple Ridge and Mission.....	H. Fawcett
1930	Chilliwack City.....	Helen Peters
	Penticton (reorganixed).....	M.A. Twiddy
	Summerland.....	O. Ings
	Revelstoke.....	A.E. Lee
	North Vancouver.....	Norah Armstrong
	.....	E. Lowther
1931	Westbank.....	Hilda Barton
	Lake Cowichan.....	V. Miller
1932	Rolla.....	Nancy Dunn
1935	Ft. St. John.....	Nancy Cunningham
	Dawson Creek.....	Rita Mahon
	Progress.....	Pauline Yaholnitsky
	Abbotsford.....	J. Arnould
1936	Richmond.....	Muriel Upshall
	.....	Eileen Williams
1937	Prince Rupert.....	Dorothy Priestly
	Nelson.....	Kay Gordon
	Burnaby.....	Mary Shand
	.....	Alice Thornloe
	West Vancouver.....	Ethel Brooks
1938	Matsqui-Sumas-Abbotsford.....	Beth Ochs
	.....	Evelyn Maguire
	.....	Marion Miles

	Maple Ridge	Anna Larson
	Dewdney.....	Mary Grierson
	Gibson's.....	Lillian Wooding
	Port Alberni (reorganized).....	Joyce Leslie
1939	Lumby.....	Marion Bellis
1940	Quesnel.....	Pauline Yaholnitsky
	Fernie and District	Joanne Daem
	Cranbrook	Bertha Jenkins
1941	Creston and District.....	Marion Miles
	Courtenay.....	Alice Beattie
	Coquitlam and Fraser Mills.....	Freda Hilton
	Kimberley.....	Anna Larson
1942	Sidney.....	Kay Ellis
	Cranbrook and District (reorg.)	Isabel Louks
	Prince George.....	Eileen Snowden
1943	Alberni	Mary Gregory
	Williams Lake	Viola Davies
	Powell River.....	Eleanor Graham
	Princeton	M. Betsy Quayle
1944	Rossland	Elizabeth Hahn
	Cumberland.....	Lucille Giovando
	Nakusp.....	Marjorie Standiforth
1945	Agassiz.....	Betty Picard
	Campbell River.....	Violet Hele
	Surrey Municipality.....	Ann Elyea
	Langley.....	Frances Stewart
	.....	Eillen Snowden
	Hope and District	Susie Jones
	Salmon Arm and District.....	Phyllis Purslow
	Equimalt Municipality (reorg.)	Merle Franke
1946	Delta Minicipality	Barbara Smith
	Oliver (reorganized)	Janet Pallister
	Alberni Canal.....	M. Betsy Quayle
	Trail.....	Evelyn Teir
	Slocan	Nora Woods
	Fruitvale - Salmo.....	Elizabeth Ochs
	Kamloops (reorganized)	Margaret Campbell

Source: Monica Green, *Through the Years with Public Health Nursing* (Ottawa: Canadian Public Health Association, 1984), pp.158-160.

Appendix B

A Day in the Life

"AN OPEN LETTER."

Royal Oak P.O.,
Saanich, B.C., May, 1936

DEAR VERA, — You have often asked how I spend my days, so here goes.

8 a.m. The phone rings and I answer: "Hello. Yes, this is one of the nurses speaking. You would like me to call at Mrs. Mortimer's, Tillicum Road, give general care and report her condition to you later on? All right, Doctor."

(Our phone rings frequently in the morning; often just as we are leaving the house with a cod-lover-oil can in one hand and a bag in the other, with a book tucked under one arm.)

I arrive at Tillicum School in time to see several teachers before the 9-o'clock bell rings. Miss Rickwell, the Primary Grade teacher, appears to be puzzled over something. A new pupil has arrived and caused a commotion in an otherwise well-ordered class-room. He stutters! The more his attention is drawn to it the more pronounced it becomes. The child's book-work is very good; reading and oral work handicapped by stammering. We decide that his mother might consent to an examination by a psychiatrist at the child-guidance clinic. This will mean a visit within a day or two to make arrangements.

In Grade IV, the teacher reports the absence of a child who misses about a week every month with a cold or upset stomach. I have visited the mother time and again, making inquiries and offering suggestions. So far I cannot see that I've accomplished one thing.

The principal hands me a note from a parent which reads: "Nora needs a new scribbler and art pencil. Would the school please provide them?" I know the circumstances of the family well enough to know that 15 cents in school supplies means a bottle of milk less at home. Nora will receive a book and pencil.

For the next half-hour children come to my office to have cuts dressed; while others come for readmission certificates after being away from school. In the meantime a list is made of the absentees in each room, and fortunately it isn't such a formidable one to-day.

I make a call on Mrs. Mortimer, who lives only a few blocks away from the school, and spend an hour carrying out the doctor's orders. The first visit is always the longest, because one never knows where to find towels, soap, basin, or clean linen!

My next call is to a little girl named Patsy Jefferson, because a neighbour has reported that the child has brown, ring-like sores over her neck. Fortunately, Patsy is playing in the front of her home with Jimmy, whom I know. While I am talking to them, Mrs. Jefferson comes out and tells me all about her little girl while I try to sandwich in. I hope when I go back in two days that there will be an improvement.

About 10.30 I telephone to the office to see if there are any calls. Sure enough; Mrs. Lehane would like to see a nurse. There is not address; I am to get that from the postmaster; and no reason give for the visit. The postmaster knows three families by that name; one wouldn't have anything to do the the Health Department, that eliminates them for the time being; another is an elderly couple, half a mile north; the other is a family with four children. The latter is the right one. I cannot do anything when I arrive. A patient with a high temperature and abdominal pain needs a doctor. A message come later saying Dr. Jones has sent Reynold to hospital.

On the way home for dinner I drop in to see Mrs. Holiday. The dear old lady was held up two nights ago, gagged and bound to a chair. She has some bad bruises and cuts that we attend to. It cheers her up to have company.

Referring to the absentee list again, I enjoy ticking the names off as I make the rounds. First this afternoon is a boy who had been away for three days with a cold. He is better, but is inspected and given a certificate to return to school. There are several other calls made for a similar reason.

I am in difficulty, though, when one boy with chicken-pox says he has been playing with others the day before. These other boys' mothers cannot see why their children should be allowed to go to school for a while, then be kept at home for a given period. I am in disfavour up and down the street.

Then there is Myrtle Ross, a stenographer, who has rubella. I nearly always ask these people where they think they might have been exposed to infection. It's very interesting to hear some of the tales. Myrtle thought she had contracted the infection from a girl with whom she works. I was a bit doubtful. During our conversation she tells me about a party she had attended. Three of the boys has rubella the next day. One was her friend. She hadn't seen him for six months, so I don't expect she would stay ten feet away from him. It was eighteen days after this party that Myrtle had a rash.

About 3.30 every Tuesday and Friday I give Mrs. Saunders a hypo. She always offers me a cup of tea. It's one of the things I look forward to these days.

Mrs. Pearson is my last visit. She is a prenatal and expects to be confined at home. Just as likely as not she will have her baby to-night. Am I glad I'm not on duty? It won't be my night that is going to be disturbed.

I am certainly tired so will end my letter right here.

Yours,

DOROTHY TATE¹

¹Dorothy Tate, "An Open Letter," *PHNB* (1936), pp.42-44.

Appendix C

“Transportation”

“The means of transportation for the Public Health Nurse has always, I believe, been a bit of a problem, especially in a rural district.

The question is how to get the nurse conveyed to and from her work, be it patients, schools, clinics, etc., with the least possible expenditure of money, of her time, and of her energy.

There are, of course, many ways she may travel — from aeroplane to snow-shoes — but not all equally practicable. The means of transportation has to be suitable to local conditions, and usually the cost of maintenance is of vital importance.

If it is financially possible, of course, a small car is the ideal; that is, when climatic and road conditions are equally possible.

I have now worked north of the Peace River for five years, and have travelled to my patients and to vary scattered schools, etc., in very many different ways.

At first there was the old Ford, car, lent to the nurse “for the duration” (of the car!). “Eliza” was a faithful old car, even if not much to look at. She certainly lacked many things that the average car is expected to possess; but she had a wonderful engine (so every one said) and a very willing spirit, and altogether a nice disposition. Many a time she was left in a mud-hole or astride a stump while I journeyed on to my patient of foot; but she was useful on the roads and saved much time. The horse was used for the trails and more difficult trips, and during the many months of the year when “Eliza” was snowed up or laid off on account of mud. Of course, she was an expensive to run, with gasoline at 50 cents a gallon; very shaky and bumpy to rid in; also draughty after the glass in her wind-shield was bumped out, and dreadfully noisy, but there were many regrets when she finally gave up the ghost. Her engine now saws wood in Fort St. John, while her body, converted into a sort of buggy, is pulled around by horses! How the mighty have fallen!

After the demise of the car I stayed steadily with the saddle-horse, varied by “Shank’s Mare,” except when I was fetched to a patient, when I travelled in a diversity of rigs — from a stone-boat to a dog-sleigh, including a hay-rack, a grain-box wagon, a home-made cutter, a comfortable heated caboose, a bob-sleigh, and many others.

Generally speaking, the roads have improved in the last few years, making transportation easier; but there are still parts of my district almost impossible to get at, except in winter, on account of the muskegs. The steep hills with their winding, precipitous roads present a very real obstacle to easy and safe travelling, especially after a

Chinook, when the surface becomes glare-ice. Taking a patient to a hospital over such a hill is quite a difficult procedure and requires real team-work.

At one time, transporting an old lady with a dislocated shoulder, we made a safe journey down an icy hill by several men going ahead early in the morning with picks and cutting a groove in the ice to take the sleigh runners at the most dangerous points, while another man riding a steady sharp-shod horse was hitched on behind the sleigh to act as an anchor and hold it from swinging around. It was a rather a perilous ride, but, fortunately, the patient was the least concerned of the party, and we reached the bottom safely and thankful. The hill on the south bank of the river was less icy and more easily navigated.

Riding horseback when the temperature is very far below zero is a cold business, and then, if time permits, I prefer to walk. At present I am considering training my two dogs to pull me on a light toboggan. With such a small team I could not expect to go far or over bad trails, but they might manage my hundred pounds on good trails, and it would be decidedly warmer than perched up on a horse.

Of all the many ways I have travelled to visit a patient, perhaps the most unusually (and undignified) was on hands and knees.

Hearing that there was a sick child on the others side of the lake, I left my unshod horse at the house I was visiting; I proceeded to walk the odd half-mile or so across the ice, as advised, instead of going 2 or 3 miles around. For some little way out from the shore the ice was comfortably covered with snow, but out in the wind-swept centre it was plain well-polished ice and I found myself sitting down suddenly every few yards. Finally, in desperation, I took to my hands and knees and crawled across the laked nearly to my patient's door.

Surely there are many ways for a nurse to travel her district!¹

¹Muriel Claxton, "Transportation," *PHNB* (1936), p.9.

Appendix D

“Then and Now”

“When I graduated as a Public Health Nurse I had very definite ideas about how I would organize in a new district. First I would have a good-sized photograph on the front page of the local paper, at least a month before I would arrive, with the announcement of said arrival, all my credential published, etc. I had visions of closing hospitals and seeing all the people living a strictly hygienic life. All children would soon drink milk, eat lettuce, and be in bed at 8 every nigh. There would be no cancers, tuberculosis, or any infections diseases in the district as a result of my public-health programme. All this, and even more, was to be quite fully accomplished in at least four or five years. These visions came in spite of being warned in classes that we must expect the work to move slowly, etc.; but *I* would make things hum when I started in a district of my own. I would get school-work well established; hold a baby clinic each week, with all the babies in town attending; have a monthly T.B. clinic; be in every home and know every man, woman, and child by their first name, in the first year.

So much for untried theories — now something practical. This is another story.

When I arrive in the district I find that many have not seen the paper containing my advance notice, and have never heard of me — did not even know there was to be a nurse — a Public Health Nurse. What does she do, anyway?

After much explaining here and there in small groups and in homes for a few months, people begin to know who I am and something about the work I am trying to do. I soon find out that great distances, weather, and many factors prevent having baby clinics for some time; in fact, I was in one district three years before I even had a weighing-station running properly. I had for a long time to be content with seeing a few babies in the homes. There is no doctor to take charge of the T.B. clinic, so that plan must be tabled for the time being. Many people cannot afford to pay the doctor and dentist, so correction of defects in children must be delayed. So one works on for months amidst this delay and

that, and finally must feel resigned to report about one-third as much work really accomplished as was first planned....

Perhaps I have allowed the pendulum to swing too far the other way and am content with too little, but I believe I have really learned now that Rome was not built in a day.”¹

¹M.A. Twiddy, “Then and Now,” *PHNB* (1931), pp.13-14.

Appendix E

Number of Public Health Nurses, British Columbia, 1917-48*

Year	No of PHNs	Comments
1917	1	April 13, 1917 first appointment of a public health nurse in British Columbia was made at Saanich ¹
1921	15	15 "have been placed in the field" ²
1922	19	12 Prov. Board of Health, 7 Red Cross ³
1922	4	4-Dept. of PH, 17-Dept. of Ed., 19-VON, 17-Other priv. agencies= total 57 ⁴
1923	5	3 to Saanich, 2 to Duncan
1923	16	"We have at present in British Columbia sixteen nurses" ⁵
1926	26	"We have now twenty-six nurse in the field, not counting our school nurses in the larger centres." ⁶
1927	40+	"Our Nursing Service is increasing and the number of nurses at present connected with our work is upwards of forty." ⁷
1928	50	25-public health nurses, 25-school nurses ⁸
1930	62	32-public health nurses, 30 school nurses ⁹
1931	73	including both public health and school nurses ¹⁰
1938	90	we have now ninety nurse, all trained, and who were sent out to centres ¹¹ (these might be new grads)
1940	92	85 plus 7 employed in school work ¹²
1942	47?	(not including school) 10 new, 7 married but only 4 resigned, 5 resigned- net +1
1948	182	182 official agencies/46 non-official agencies=228 ¹³

* Note: Some of the sources use diferent definitions of public health nursing and produce conflicting statistics. For example, some of the sources separate public health nurses doing exclusively school work, from those who do a generalized program.

¹Marshall, Defries ed., p.107.

²Henry Esson Young, *RPBH* (1921), p.7.

³Henry Esson Young, *RPBH* (1922), p.6.

⁴*Public Health Journal* (Feb. 1922), p.86

⁵Henry Esson Young, *RPBH* (1923), p.6.

⁶Henry Esson Young, *RPBH* (1926), p.5.

⁷Henry Esson Young, *RPBH* (1927), p.17.

⁸Henry Esson Young, *RPBH* (1928), p.7.

⁹Henry Esson Young, *RPBH* (1930), p.9.

¹⁰Henry Esson Young, *RPBH* (1931), p.8.

¹¹Henry Esson Young, *RPBH* (1938), p.3.

¹²Marshall, Defries ed., p.107.

¹³Canadian Public Health Association, *Report of the Study Committee on Public Health Practice in Canada* (Toronto: Canadian Public Health Association, 1950), p.75

List of Abbreviations

V.O.N.	Victorian Order of Nurses
G.N.A.B.C.	Graduate Nurses' Association of British Columbia
<i>PHJ</i>	<i>Public Health Journal</i>
<i>RPBH</i>	<i>Report of the Provincial Board of Health</i>
<i>PHNB</i>	<i>Public Health Nurses' Bulletin</i>

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