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Abstract. In October 1920, the provincial Board of Health of Ontario sent 16 public health nurses to the northern and rural parts of the province to "educate" mothers in an attempt to lower the unacceptably high infant mortality rate. This research examines the relationship between the official perceptions and actions of the Board in relation to the child welfare project and the actual experiences of the nurses in two small communities, Kenora and Bowmanville. It will be argued that knowledge is a necessary but not sufficient means to better health. The Board's focus on "health education," however delivered by the nurses, would not erase the effects of poverty, nor replace the lack of expert care for confinements or serious illness. Health education was a facile solution to the serious problem of the lack of permanent human and material resources, particularly in Northern and Eastern Ontario. Specific research at the local level is necessary to establish public health measures as effective agents of social change.

Résumé. En octobre 1920, le «Board of Health of Ontario» a envoyé seize infirmières-hygiénistes dans les régions du nord rural de la province, pour «éduquer» les mères et tenter de réduire le taux inacceptablement élevé de mortalité infantile. Cette recherche étudie le relation entre, d'un côté, les perceptions et interventions officielles du «Board» et, de l'autre, le projet de bien-être de l'enfant et les expériences vécues par les infirmières dans les petites collectivités visitées. On se propose de montrer que les connaissances sont un moyen nécessaire mais non suffisant dans la recherche de l'amélioration de la santé. La prééminence accordée par le «Board» à l'éducation sanitaire, bien qu'elle ait été actualisée de manière créative par les infirmières, n'a pas suffi, cependant, pour combattre les effets de la pauvreté ou pour pallier à l'insuffisance de soins compétents dans les cas d'accouchement et de maladie grave. L'éducation sanitaire s'est avérée n'être qu'une solution superficielle au problème grave du manque endémique de ressources humaines et matérielles,

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The historiography of the public health movement in Canada has generally been framed by one of three approaches: first, the continuity of "progress" and the glorification of results; second, humanitarian action to save lives and improve health; or third, social control of the working class by elites.¹ The Ontario Provincial Board of Health's child welfare demonstration project of the 1920s provides a case study for proceeding in another analytic direction. The research reported here analyzed the relationship between the official perceptions and actions of the Board of Health and the actual experiences of the public health nurses who were the front-line workers of the new movement. By focussing on several Ontario communities in the 1920s, public health nursing was seen as part of the "web of relationships" that constituted social reality in rural and small town Ontario. The rural setting has been relatively neglected as an area of study both in social and in medical history. This research is a partial attempt to fill that gap.² In addition, our knowledge about such projects has been described from the "top down," by the policy-makers, rather than by the central actors themselves. In the early twentieth century, nurses were the vanguard for the new public health movement. 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.³

A great deal of rich documentary evidence, offered by the workers themselves, provides another perspective. Actual day-to-day work was examined through the use of such routinely-generated sources as the public health nurses' correspondence to superiors and their field reports. To analyze the official discourse of the Board of Health, I have used evidence in the Annual Reports, 1910 to 1930, and also the memoranda and papers of the Chief Medical Officer and other officials. A typed transcript of the 1917 Board meeting at which it discussed the project was also valuable.⁴ This paper is based on the results of the two public health nursing demonstrations in the towns of Kenora and Bowmanville. Patterns across Ontario generally support the evidence provided in these two diverse geographical and economic areas.

Counterposing "discourse" and actual experience befits the social historiography of the 1980s, particularly in the field of the history of education. Alison Prentice, and others, have written about female elementary school teachers and their work responses to school inspectors, and rural as well as urban teaching conditions. The
teachers' need for respectable, independent careers that would earn them a living wage paralleled middle-class nurses' wish for meaningful, challenging work in the post-war period. Marta Danylewycz's work on Quebec nuns also takes this approach, reinterpretting nuns' lives in light of the official discourse of the church and society in relation to their own lived experiences as teachers and nurses.

In order to analyze the historical context of the child welfare project we need to examine both ideology and experience. In doing this, I asked such questions as: What were the Board members' beliefs about rural dwellers and about the role of the Central Board? What did the nurses find when they visited rural and small-town families? What were the strategies the nurses used to deal with the constraints placed on them, as women, and with the problems of rural people? What were the explanations put forward for the lack of success of the demonstrations?

On 5 March 1917, the Board of Health resolved to hire seven public health nurses, and to send them out to each of the Health Districts of the province. This resolution marked the beginning of the state's commitment to the subsequent project—initiated in 1920 and terminated in 1925—and to the use of female public health nurses as the major line of offence in the public health scientists' campaign to lower the infant and child mortality rate. They would accomplish this through the education of Ontario mothers, whom they perceived to be ignorant of proper methods of infant and child care. Another major purpose of the project was to convince the local, rural boards of health to continue the work by hiring nurses themselves after the demonstrations were completed. In this way, central Board members would finally put into practice their motto, "Let not the people perish for lack of knowledge," by providing predominantly small-town and rural people with the information that the Board believed they needed in order to lead healthier lives.

Generally, the hope that local boards would follow the lead and hire a nurse did not materialize. Although the infant mortality rate did drop, this was probably due not to the "teaching" but to increased registration of births and to immunization programs. Municipalities were unable or unwilling to hire public health nurses: only 8 nurses were ever appointed as a direct result of the over 100 demonstrations between 1920 and 1923 alone. By 1925, it was all over, and the Board blamed "ignorance" of the public and local boards that would not accept its ideas and programs. The Boards also indirectly implicated private physicians, who, it believed, resented "interference" in their practices. Their firm belief in such solutions as "health education" to solve intractable problems, primarily caused by the material conditions of people's lives, was deeply rooted in the diverse and, at times, contradictory ideology of Anglo-American public health reformers.
THE BOARD'S BELIEFS

Two major concerns underlay the Board's decision to commit themselves to the child welfare project. First, losses experienced during the Great War sustained a pro-natalist attitude in society and fueled the already strong social gospel belief in the need to save the child from eternal damnation and an immoral, unhealthy family. Such exhortations as "the child fresh from the hand of God is the foundation of all constructive work for human betterment" were typical. Furthermore, Ontario's high infant mortality rate ("the supreme test of sanitary rank") compared unfavourably with that of Great Britain, New Zealand, and the United States. In 1916, Ontario's rate was 107 deaths per 1000 live births; the rate was 90 in Great Britain and 50 in the world leader, New Zealand. Ontario cities and towns fared the worst: cities lost 116 per 1000 and towns, 128. The rate in non-urban areas was 90. As an additional incentive, reformers assumed that if the environment was healthy enough for infants to survive their first year, it was healthy enough for everyone. Death rates at all ages could then be expected to decrease.

The Board of Health was not alone in its focus on the child. Indeed, between the 1880s and 1920, "... a growing band of English Canadians... worked to change the nature and improve the quality of family life, to establish new systems of child and family welfare, to transform Canadian education, and to organize child and family health care." The cry that "the baby is a citizen," with rights to certain standards of care from parents and society, came from many middle-class women, men, and professionals. Furthermore, the economic argument for "baby-saving" apparently appealed to the business instincts of the Board members. It was said that the monetary value of a baby was $90 and since it cost $50 to bury a babe, it made good financial sense to keep it alive. One reformer affirmed that "... a dead baby is a liability till its funeral is paid. But a living baby is an asset and liable to grow into a good Canadian." To Dr. McCullough, the Chief Medical Officer, public health was a "business" and since disease was "the highest cause of poverty," if one prevented disease, one would have prosperity. The ideology of efficiency in business and factory was being applied to the human body, now a "machine." Health—"in its true sense"—was the "highest physical efficiency prolonged for the greatest period of time."

Losses sustained during the Great War were a powerful incentive for Canadians to preserve and improve the health status of the population. Appalled at the poor state of health of many of the recruits—35 to 40 percent were rejected as unfit—and the "waste and wreckage of lives," officials saw it as the patriotic duty of all Canadians to save themselves and future generations from the fate of ill health and
premature death. For example, the Toronto Board of Health reproduced David Lloyd George’s “Health Speech” of August 1918 in their Annual Report, in an attempt to garner support for some programs and to rationalize others. Lloyd George called for a “... constant and more intelligent interest in the health and fitness of the people.” The very future of the Empire depended upon it; there was “no surer way of strengthening the country” than to focus on the children and on their environment, “the most important workshop, the home.” Above all, bad health for the nation was “bad business for all.” Dr. W. H. Hattie, the Nova Scotia health officer, put it this way in a speech in 1917:

The most effective way to offset the loss of life which the war is causing is to prevent needless death at home—the most effective way to offset the loss of property and wealth is to make our people physically and mentally capable of meeting the enormous demands which the work of rehabilitation will force upon them. To accomplish such a task is the obvious and patriotic duty of those engaged in the public health service.

The second concern of the Board was related to the local boards of health. The central Board had been trying to keep the small-town, local boards of health compliant with the Public Health Act since it had been legislated in 1882, and it perceived them to be generally uncooperative and unwilling to expend funds in support of public health measures. It became compulsory to re-organize on a local level in 1884 when the Public Health Act was revised. In that year, there were over 600 local boards, many being activated only when an epidemic threatened. In 1890, it was compulsory for every local board to appoint a medical health officer (MHO) who was responsible for advising the board and carrying out surveillance and enforcement duties as stipulated by the Act. Thus, despite the Board’s central authority, local municipalities were presumed sovereign in enforcing quarantine and vaccination, in part because epidemic diseases such as smallpox and cholera were typically confined to small areas, and also because many local politicians resented government interference. Furthermore, the size of the province precluded individual supervision of each municipality by the Board.

By 1910, many municipalities had a board and officers, but one of the major sources of friction was the part-time, local medical health officer. The MHO in small municipalities and countries was a local doctor who was trying to make an income and establish a reputation by practicing medicine. He frequently knew very little about public health measures, was poorly paid by urban standards, and was in his position at the pleasure of the local board, composed of businessmen, clergy, and possibly the mayor. Often, if he displeased these pillars of the community, he was fired and someone else would take his place. Dr.
McCullough expressed some sympathy with the small-town MHO in explaining the problem:

It cannot be expected that a busy medical man who is paid little or nothing for his services... will risk treading on the toes of his patrons by enforcing laws and regulations which are often regarded by the latter as interference with their freedom. It is a case of serving two masters, his own interest or that of the municipality which the Divine word decries impossible. 

According to Dr. McCullough, except in large cities (notably Toronto, Hamilton, London, and Ottawa), the MHOs were part-time officers who often earned little except frustration for their enforcement of the Public Health Act. Moreover, at least one town clerk was in agreement with the Board that many local boards were a "farce," being "... influenced more by complaints made by a few incompetent, unthinking, faultfinding [sic] farmers than they can be by matters of much greater importance." However, one rural MHO defended himself in the *Public Health Journal* by saying that the urban officer had "more resources at his disposal" whereas in the country he toiled alone, with little but sunlight and nature on his side. Another MHO confirmed that he had "to go very slowly" since many of the small-town residents were retired farmers "living on a small amount annually and are content to go along in an easy way." In 1912, the Act was revised as McCullough and the Board attempted to control the frequent dismissal of rural medical officers of health by their boards. The Act now stipulated that MHOs were permanently in their positions. That is, they could not be dismissed "except for cause and with consent of the Board." 

At this time, the main concern of the Board was still the control of communicable disease. This was accomplished initially through the enforced construction of sewers and water treatment plants, as knowledge from the science of bacteriology and the technology of engineering became more rapidly available. A Provincial Sanitary Engineer was hired in order to advise municipalities in these matters and to inspect new facilities. All these measures were clearly an attempt by the Board to exercise control over rural and small town boards, even though local councils were responsible for funding their own affairs. However, according to the Board, sanitary conditions in rural towns and schools left much to be desired and frequent outbursts of communicable disease, particularly infant diarrhea, were proof of what they perceived to be ignorance of, and indifference to, healthy ways of living. Thus, in order to ensure compliance, female public health nurses became the answer to the need for cheap, well-trained, and committed workers in the effort to disseminate the necessary knowledge to bring new health and life to the rural parts of Ontario. The comparatively low cost of her
salary relative to the efficiency of her work was explained in the following way:

Because a doctor costs about twice as much as the nurse, it is the policy of the department to have the public health nurse do as much work as she can thus making it possible for the public health physician to spend all his valuable time doing only those things that demand this special skill and training.23

Although the Board had no specific department devoted to maternal and child health until 1916, McCullough was aware of the work of the American Federal Children’s Bureau (established in 1912), of the infant mortality reports issued by the English Local Government Board (in 1919 renamed the Ministry of Health) and of Ontario’s own reports, which drew heavily on the American and English models.24 Several Ontario cities, foremost among them Toronto, had hired public health nurses to work with mothers and children, and their work was becoming well known. Indeed, one public health leader enthused: “The entire modern Health Movement depends upon the adequate development of the visiting nurse.”25 As “prevention through education” increasingly became the watchword of the Board, McCullough saw nurses as the ideal workers to educate and supervise mothers and children.

Undoubtedly, Toronto’s highly successful public health nursing department—established in 1911—influenced McCullough’s view that the PHN was the “central pivot of all the scheme . . . the warp which binds the whole fabric together.”26 In 1914, Toronto had established a generalized nursing program, with all services such as school, tuberculosis, and infant welfare under the Division of Public Health Nurses. In 1915, 37 public health nurses reported to Eunice Dyke, the dynamic Superintendent of Nurses. City PHNs had succeeded in lowering infant mortality in Toronto by careful supervision of poor, pregnant women who delivered at the Burnside Lying-In Hospital and, in 1921, were credited by Dr. Hastings, the MHO, with achieving the “lowest mortality rate on record.”27

Not everyone was convinced, however, that public health nurses were the solution to infant mortality. Miss Dyke, tongue-in-cheek, did not hesitate to recount the following anecdote to the Canadian Conference of Charities and Corrections concerning one physician’s reaction:

Dr. Bryce is a welcome visitor to our Department, because he compels us to analyze our statements of results obtained. . . . Fearing that the public health nurses might over-estimate the value of their efforts in obtaining the steady reduction in Toronto’s infant mortality, he insisted recently upon extracting statements from us of other possible factors resulting in the reduction. Finally he remarked, “Don’t you think the weather may account for it?”28
Dr. McCullough believed the nurse was needed to visit mothers at home "in order to check them up and arrange their time to come" to the Infant Welfare Centre because "... the ignorant, careless woman will find excuses to keep away."29 As well, those who could not read the English-language literature that the Board distributed were seen to need "personal instruction" because "... they are often the most careless."30 Visiting nurses, caring for the sick, were already familiar to many impoverished urban immigrants; it was expected that this familiarity would aid public health nurses in being well received. Indeed, as Eunice Dyke commented: "The term 'Public Health Nurse' has its limitations. The term 'nurse' carries with it traditions of service which are narrower than the new opportunities, but we cling to the name because of the entry which it gives to the home."31

Indeed, the public health nurse was hailed as "a sort of community mother but armed with the expert knowledge that few mothers can possess."32 Never intending to provide a continuous service to communities, Board members believed that once the nurse had demonstrated the value of public health work, each municipality would "see the light" and then willingly fund it themselves.

THE NURSES’ EXPERIENCES

Kenora

In October 1920, Marguerite Carr-Harris was sent with another nurse to Health District Seven, which comprised 90,000 square miles in the extreme northwestern parts of the province. The towns and villages were often joined only by railway lines—no roads connected them, only "wild land." One-fifth of the area was organized into municipalities (56,000 people), but the population of unorganized settlers, mostly living outside towns and villages, was unknown. Many lived in very isolated conditions. The people were primarily of British, Scandinavian and Eastern European origin. The daughter of an eminent Kingston, Ontario, civil engineer, Carr-Harris was 41, single, and a decorated nursing sister of the Great War. She had been keen to go to the North, seeking adventure and loving the freedom of the "great outdoors."33

Carr-Harris’s mission was to minister to the whole district. However, she began her demonstration in the town of Kenora, a central collection point in the fur trade until the railway was built in 1880. By the 1920s pulp and paper, as well as flour mills and the railroad, were the main sources of employment. Upon arrival in the community, after finding a place to live and notifying head office of the mailing address, it was expected that Carr-Harris would visit all influential and potentially interested citizens, especially women’s groups and church
organizations. The mayor, Council members, and members of the Board of Trade and Chamber of Commerce were all expected to send representatives to a committee meeting to discuss and sponsor the nurse’s work in the town. She was to visit the physicians individually, but only after they had been approached by a member of the medical staff of head office. This action would presumably head off any "conflict," which was to be avoided at all cost.34

Carr-Harris’s work was to consist of “demonstrating” public health nursing through the following rather daunting list of activities: obtaining lists of all births within the previous two years; visiting all “registered” babies and expectant mothers at home; making a special effort to find “unregistered” babies; giving mothers “council [sic] and demonstrations in all matters pertaining to health, sanitation, hygiene and healthful living;” gathering all information possible on cases of tuberculosis, “mental deficiency,” communicable disease, and bad sanitary conditions, and report all such findings to Head Office; directing and coordinating the work of voluntary agencies and workers in the event of epidemics, and carrying out bedside nursing “in cases of absolute emergency,” teaching by demonstration a member of the family; holding clinics for preschoolers; and inspecting all school children after getting permission from the local Board of Education. She was to send daily and monthly reports back to head office and also make visits to the surrounding towns and villages.35

Despite being 1,000 miles away from Toronto, and lacking any real supervision from their superiors, the nurses’ operating “Regulations” cautioned them against suggesting treatment or diagnosis to their patients, indeed, even against “advancing opinions.” Family physicians were to be notified in writing, after the nurse made the first visit, and future visits were to be deferred pending his reply. If a physician should object to the visits, “they must cease immediately.” Public health nursing ethics, provided by American leader Mary Gardner in her textbook, reiterated this prescription: “[E]ach case belongs professionally to the doctor and not to the nurse.” Nurses were also forbidden to give “material relief” to their patients.36

Undoubtedly, it was considered dangerous for the profession to breach these rules. However, given the often appalling living conditions of the population, particularly in outlying areas, and the lack of expertise of many of the local physicians, these rules must have placed the nurses in a constant situation of internal conflict. On the one hand, the extent of responsibility that they had for the success or failure of the project precluded a passive and subordinate stance. On the other hand, their acceptance of professional protocol and the social expectations of their gender meant that they must defer to physicians and to local politicians.
For Marguerite Carr-Harris in Kenora, there were frustrations, obstacles and some small triumphs. Although the women's groups and the clergymen were eager to cooperate and be “good centres radiating the wide view of public health,” the mayor, a local businessman, was not supportive, nor were any of the physicians in the beginning. She noted that there was a strong feeling of distrust in the North towards “experts” from the South, who were also perceived as exploiters of the vast natural resources. Although a new pulp mill was being built, she reported that the town was “not in a money-giving frame of mind” and that the townspeople were barely able to “clothe, feed and educate their little families,” being mostly labouring people. Taxes had already been increased to make up for earlier losses and a new water bill was preoccupying the town council.

In teaching preventive measures, the nurses often came into conflict with physicians’ orders, particularly with regard to infant feeding. Breastfeeding was acknowledged by most pediatricians and public health workers as the best prevention for infant diarrhea, a major cause of death. But many of the nurses viewed this as “lip service,” since bottle feeding was encouraged, even by doctors. To complicate matters many rural physicians were ill-informed about artificial infant feeding practices. Mothers often called the nurses to visit sick babies, especially if they could not afford the doctor. However, babies under the care of physicians became an issue when the doctor would order a bottle while the nurse was attempting to teach the importance of breastfeeding.

How should the nurse act in this situation, or in the situation of epidemic whooping cough when Carr-Harris advised those not yet infected to go to their doctor for immunization? After driving 25 miles, the family was refused by the doctor because “nothing can be done.”

In the townships and villages of District Seven, Carr-Harris reported that there never was a question of getting a nurse appointed. The settlers were either “unorganized” or the town or village was too poor to appoint a nurse. Everywhere in Ontario, particularly in the northern and eastern parts, there was poverty and a lack of medical resources, particularly for obstetrical and confinement care. Women, many of them Scandinavian or Eastern European immigrants, were required to bear and raise their children alone as the men were away in the bush or on the railway. When their confinement date drew near there was no doctor available for miles, and when he did come the charge was more than they could pay. Women were dependent on each other and, sometimes, on elderly midwives who had no instruments but their hands.

In Kenora, Carr-Harris had been more hopeful about the chances of the town permanently supporting a nurse. Most of the physicians became friends and supporters after they saw the response of mothers, and began to trust the nurses the longer they worked together. After
six months of hard work, the council voted down the request for a nurse, by a small margin. The mayor and the powerful pulp and paper representative never "came around" and Carr-Harris was forced to accept the verdict. She moved on to another town. These results were typical of those across Ontario, where municipalities did not want to raise taxes to pay for a nurse, but wished that the service be provided by the Central Board.

Bowmanville

Marjorie Heeley, the immigrant daughter of an English silversmith, was assigned to District Four and, in September 1921, she went to Bowmanville to demonstrate public health nursing. In November 1921, she made her first official report on her work in the town. Bowmanville was a town comprising 3,250 people, situated about 60 miles east of Toronto, "about one and half miles from the shore of Lake Ontario." Because of its attractive "spaciousness," Heeley believed "... that the place ought to be a healthy one." Six large factories presumably provided most of the employment, although agriculture was also important: there were several farms within the limits of the town. Bowmanville was blessed by an excellent supply of spring water and "comparative freedom" from epidemics, although there was no garbage collection, no routine milk inspection, and many people used wells rather than the town water supply. Like many towns, the Sanitary Inspector was also the Chief of Police, the Truant Officer, and the Tax Collector.

By the 1920s, Bowmanville was ready for a public health nurse. Heeley believed that she had "secured the interest of many of the citizens and especially the cooperation of the women... from the beginning." The Medical Officer of Health, Dr. Hazlewood, was "keenly interested in all that pertains to the welfare of the town" and had requested that a nurse be sent to Bowmanville. Upon her arrival, Heeley visited many of the so-called influential people—the mayor, members of town council, the doctors, the school board, the managers and owners of the factories, and "especially the ministers." She found two organizations of women "... more or less prepared for her coming, and ready to cooperate": the Women's Institute and the Women's Canadian Club. She addressed their meetings and they agreed to furnish her office in the Town Hall and to assist at the Child Welfare Clinics by serving tea, by helping to dress and undress the children, and in the clerical work. As well, Heeley later reported that "... several cases of poverty were materially assisted by the cooperation of the ladies of the town."

In her report, Heeley commented on the spirit of cooperation met on every hand. The churches announced the nurse's activities week by
week, and the Ladies' Associations of the churches prepared and collected layettes and other garments needed for the poor. Furthermore, the merchants of the town cooperated by loaning beds for the home-nursing classes and scales for weighing the babies as well as providing free eye examinations by the Optometrists and Opticians. The local newspapers "... devoted considerable space to the doings of the Community Nurse."

After this positive beginning, Heeley's work consisted of helping a local doctor examine each of 445 school children, giving "health talks" to the children, forming "children's health leagues," and visiting the homes of absentee school children and those found with defects. (Such defects included, largely, "abnormal tonsils," "defective nasal breathing," "defective teeth," and "malnutrition.") Heeley recalled that "... school work was an entry into the homes right away." While on home visits, advice was given regarding infants and preschool children, particularly with regard to "improper feeding." In fact, Heeley recorded that advice was given 327 times and that instruction was given in 95 homes, all in two months.

Several expectant mothers were also visited and advised, although this aspect of the work seemed minor in comparison to advising on the health of children. (It is unclear whether or not she obtained a "prenatal list" from local physicians as the Division had directed.) Although the nurses were instructed to carry out bedside nursing only in cases of absolute emergency, Heeley found it necessary to make ten visits in two months to render nursing care to sick mothers and children. Other activities included organizing two Child Welfare Clinics, where the local doctors examined babies. Dr. W. J. Bell, a staff pediatrician at the Division of Maternal and Child Health and Public Health Nursing, came to one of them and was observed at the clinic by many interested visitors, including one of the town's physicians, as well as the matron and seven nurses from the local hospital and the chairman of the school board. Heeley also gave home-nursing and first aid classes to groups of teenaged girls and young women.

Once the nurse's office was outfitted, Heeley was there for consultation one hour daily. Many mothers, and at times fathers, came for advice or help, as well as others simply wanting to pass the time. Surrounding villages and hamlets also requested her to come and "explain a little of what Community Welfare Work means."

What were the results of her work? Did the town vote to appoint a nurse? On 15 November, a meeting of citizens was called to hear reports of the work and to consider "... the best methods of working to get a Public Health Nurse permanently appointed." The elected town council was considered unlikely to support the appointment, therefore the Community Child Welfare Committee voted not to approach the
council and to postpone the question until the election of a new Council and School Board. Although this was not the desired outcome of her work, Heeley noted some of the improved health conditions in the town. She included such improvements as changes made in the diets of children suffering from malnutrition, some school children being “more cleanly” in their habits and taking greater care of their teeth, as well as “marked improvement in the conduct and attention” of a boy recently fitted with glasses. No attempt had been made to evaluate the results systematically, due to lack of time; however, her supervisor, Miss Knox wrote that “… the terminations reported seem to be a fair percentage for the time spent.”

Heeley did not feel that she had had “strong organization” behind her; in fact, she had Dr. Tilley with the “longest and largest” practice as the “biggest knocker.” Acknowledging that the town was not rich, Heeley nevertheless believed that it could afford a nurse, if the right people supported it. On 5 January 1922, Heeley wrote to Power:

It is practically the same thing over again. During the demonstration people have been most interested and sympathetic, but now that it comes to a “show-down,” oppositionists are arising from every corner. All kinds of excuses and objections are being raised. Even the home nursing classes and the Mother’s Club have been mentioned as added objection to having a nurse—they will be sure to raise the cost of a nurse to at least $6,000 in the first year.

On 6 February 1922, the Child Welfare Committee went to the new town council to recommend that a community nurse be hired. The motion was rejected: five members against, three in favour. On Valentine’s Day, Heeley attended her last Mother’s Club meeting, a party at which they presented her with a gift of a club bag. She left Bowmanville on 20 February, having been invited to Belleville to begin another demonstration. In September, she returned to Bowmanville for a short time in order to put the Mother’s Club “on a sounder basis,” although she was already demonstrating elsewhere. She wrote that the idea of a school nurse was being considered in the town. But, as she put it,

…the idea of a community nurse for the present appears to be absolutely out of the question, although desire for one is still keen amongst many of the people.

Although she was clearly discouraged by her failure to have a public health nurse appointed, she had made many friends—some of them close—and she later professed to enjoying herself because she was “enthusiastic” about her work. The job was well-paying and had many “perks” that made it attractive. She was able, as she put it, “to give of myself” in a way that was not possible in hospital nursing.
IDEOLOGY AND EXPERIENCE

As it increased in complexity and numbers of workers, the public health bureaucracy constituted a major force in the role of government in Ontario by 1925. Despite the increased legal control and expanded functions of the Board, however, Dr. McCullough was not satisfied. Believing that "... there is perhaps no public health law in America more concise and satisfactory that that of Ontario," he admitted:

The progress of public health in Ontario has necessarily been slow. This has been due chiefly to the immense area of the province (403,000 square miles), the comparatively small and scattered population and the difficulty of securing financial support for what many people consider a useless expenditure of money. 48

What had gone wrong? In 1924, Miss Knox and Miss Mary Power, the Director of the branch, looked back over the "years of hard work and many disappointments" and, in an evaluative vein, attempted to analyze what had happened over the previous four years. Although asserting that "... a very large measure of success has crowned the efforts put forth," this success was not measured in the permanent appointment of nurses. As they put it:

We realize now that our method of estimating success was wrong, that our work is not primarily to secure the appointment of public health nurses in localities ... but to initiate a program of education as a result of which prospective mothers will get the care and assistance that they require, that infants will be scientifically fed, that physical defects in young children will be detected before neglect has permitted permanent damage to occur. We feel safe in maintaining now that the success of our work depends upon the energy and activity that we employ in initiating such a program. 49

The first difficulty encountered was that the public was ignorant of preventive health measures for children: "... it was not generally recognized that active supervision was necessary to ensure the conservation of Child Health." Furthermore, the role of the public health nurse had been unfamiliar:

The nurse was recognized as an agent who rendered material assistance in the capacity of highly trained bedside attendant in illness, [sic] the idea of the nurse as a health instructor had not been generally presented to the public. 50

Acknowledging that the Division had improved "conditions" for mothers and children, bringing down infant mortality "at a fairly rapid rate," Power and Knox believed it was important to make "a series of suggestions" for the future organization of well baby clinics. Their main concern focused on eliminating "interference with private medical practice": 
It is only fair to state that these clinics up to the present have worked entirely in the interests of the people but not to the financial interest of the physician, who has been helping the propaganda at his own personal sacrifice. [Emphasis added.]

In order to eliminate the "interference" it was "definitely decided" that any child who was "artificially fed" should be referred to the family doctor for "prescription." Child Health Clinics were for the well baby only, and well babies were considered those who were breast fed, gaining, and not exhibiting "fever or other gross signs of illness." Bottle-fed babies would be brought to a clinic for regular weighing, but it was the PHN's responsibility to withhold such infants from the clinic physicians for feeding instructions. In a perhaps unintended show of distrust of local practitioners, the retrospective closed with this caveat:

It is the hope and the expectation of the Department that no infant will be allowed by its medical practitioner to suffer as a result of unscientific or improper feeding instruction.

The public health nurses' perspective was provided by Miss Carr-Harris who wrote in 1922 that she believed that giving a service, as opposed to "demonstrating" public health, would give "more valuable returns in the long run" by filling "a great need." She believed that municipalities were unwilling or unable to appoint a nurse and that the "...lack of medical facilities has been one of the most powerful factors working against settlement" of the north. If the Board could give a minimum service of a periodic visit to every settler by "... a travelling Public Health Nurse... who can link the home and the individual need with the powers that govern" this action would make a good impression upon the public, commending the service of the board and helping to eventually create a demand for the service. Carr-Harris was under no illusions about the difficulty of the work and the necessity of finding nurses, who were "sufficiently interested and sufficiently faithful to give service in the future. In an aside, she added that "... those more interested in a 'good time' only lay us open to criticism." The work entailed "constant travelling" and was "arduous and often uncomfortable." The work would need to "be coordinated and directed... having an equality of hardship for the staff, and to keep each up to the same standard of efficiency."

These two perspectives, the official one by Power and Knox and the "unofficial" by Carr-Harris (who was offering her opinion), point to the discrepancies between what the Board expected would happen and what actually happened. The Board expected that the rural and northern communities would automatically accept their programs and take up the work themselves. When this did not happen, they pre-
ferred to blame ignorance of the public, as well as to indirectly implicate private physicians who resented so-called interference in their practices. Conversely, Carr-Harris saw the lack of medical facilities and the fiscal inability of local municipalities to provide public health services as the key problems. She also pointed to the arduous and uncomfortable work that was required of the nurses in the field.

SIGNIFICANCE OF THE PROJECT

What are the lessons to be learned here? Was nothing of value actually accomplished, as the Board declared the demonstrations less than successful in the attempt to reform rural Ontario? Clearly, one caveat is that knowledge is a necessary but not sufficient means to better health. The focus on “health education,” however it was delivered by the nurses, would not erase the effects of poverty nor replace the lack of expert care in the treatment of morbidity and the prevention of mortality. It was a facile solution to the serious problem of lack of permanent resources for immigrant settlers in Northern Ontario and the poor in Southern Ontario, as well as the tensions created by rural depopulation.54 Nevertheless, through the strategies of socializing with isolated mothers, organizing clubs and parties, as well as utilizing every opportunity to teach about health, the nurses were effective in showing people that someone was at least interested in their well-being. Carr-Harris noted in one of her many reports:

To be able to say to a mother living away back in the bush, “the government have sent us to see how you and your children are getting along, and if we can be of any service to you,” invariably brought not only willingness to show the children but an eagerness to get all they could out of the visit.55

Although evidence here reported fails to document change in infant mortality rates or maternal health resulting from the Board’s work, the next step in this research will be to focus on local and regional experience, examining popular sources, as well as the townspeoples’ perspective and local statistics. Recent, seminal work on Britain by Simon Szreter urges the importance of “properly researched local studies” before we conclude there is no relationship between specific preventive measures and “changing local social and epidemiological patterns.”56 We may indeed find that the role of public health agencies deserves to be given more credit than it has previously as a causative factor in social and medical change.

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NOTES


4 These documents are in the Archives of Ontario: RG 10, Series 30, and RG 62, Series F. The Provincial Board of Health Annual Reports (hereafter PBHAR) must be read with caution, since they were left partially as a record of accomplishment, seeking to place things in the best light possible. Correspondence of the nurses in the field is, of course, also suspect because they may have wanted to rationalize their own failures (and successes) to their superiors, and, undoubtedly, “filtered” much of what occurred. Typically, the population’s response to the project is lacking; only one or two letters attest to some reactions. Some relevant suggestions on the latter were offered by Katherine Arnup, “Mothers and Nurses: Enemies or Allies?” paper presented to the First National Nursing History Conference, Charlottetown, 16 June 1988, and Jane Lewis, “The Working-Class Wife and Mother and State


7 The infant mortality rate dropped from 107 in 1916 to 75.7 per 1000 live births by 1924 (PBHAR, 1925, p. 184). For an official response to the "success" of the child welfare program, see John T. Phair, "Effectiveness of Child Welfare Programs in Ontario by Survey Methods," American Journal of Public Health 23 (1933): 2. Dr. Phair became the Director of the PBH Division of Maternal and Child Hygiene in 1925.

8 Examples of this ideology can be found in Charles-Edward Amory Winslow, The Evolution and Significance of the Modern Public Health Campaign (New Haven: Yale University, 1923). Winslow, born in 1877, was a leading American bacteriologist and public health reformer who founded the Yale Department of Public Health in 1915. He also played a "leading role in the founding of the Yale School of Nursing (1923), placing great emphasis on public health nursing" (Martin Kaufman, Stuart Galishoff, and Todd L. Savitt, eds., Dictionary of American Medical Biography [Westport, Conn.: Greenwood Press, 1984], p. 811-12). Winslow and Hibbert Hill were widely quoted and acknowledged as ideologic leaders in Canadian public health. For British influences, see Anthony S. Wohl, Endangered Lives: Public Health in Victorian Britain (London: J. M. Dent & Sons Ltd., 1983). See also, Charles Rosenberg and Carroll Smith-Rosenberg, "Pietism and the Origins of the American Public Health Movement: A Note on John H. Griscom and Robert M. Hartley," Journal of the History of Medicine and Allied Sciences 23 (1968): 26-35. Middle-class women's organizations, such as the Women's Institutes, also reinforced the need to educate all mothers in domestic science. See Terry Crowley, "Madonnas Before Magdelenes: Adelaide Hoodless and the Making of the Canadian Gibson Girl," Canadian Historical Review 67 (1986): 520-47.


11 These views were expressed by Helen MacMurchy, Second Special Report, p. 19.


The speech was quoted in the Toronto section of the *PBHAR*, 1919, p. 228.

Hattie, "Some Problems," p. 689; other references to war appeared frequently at this time in many nursing and medical journals, for example, Miss Kelly, "The Relation of the Maternity Hospital to Child Welfare," *Canadian Nurse* 15 (1919): 1573-76.

A history of the PBH and the Public Health Act is to be found in *PBHAR*, 1920, p. 23-27.


Complaints by McCullough and the Board about the local MOH are to be found in all the Annual Reports from 1915 until 1930. Further, a reading of the transcript of the 5 March 1917 meeting of the PBH revealed that there was widespread distrust of the local MOH's abilities with regard to public health measures. AO, RG 8, I-1-A-1, Box 64, p. 13. McCullough also received letters from local officials, critical of their MOH. See, for example, RG 62, 1B1h, Box 450, file 11.

*PBHAR*, 1920, p. 55.


*PBHAR*, 1912, p. 7-8. An extensive report on the condition of water supplies in the province is included in this Report; much of the content of Reports of these years (1910-15) is concerned with sewage and water and their effect on health.

The problem of rural schools is mentioned in almost every report from 1912 to 1925. See for example, *PBHAR*, 1915, p. 17, and *PBHAR*, 1918, p. 27. The rationale for hiring nurses was expressed in the Toronto Department of Health Annual Report, published in *PBHAR*, 1919, p. 233.

McCullough made frequent reference to American and British systems in his memoranda to the Provincial Secretary and in the Annual Reports.

Dr. Livingstone Farrand, quoted in The Canadian Red Cross Society, Ontario Division Bulletin (1 April 1921), no. 2, n.p., AO, RG 10, 30A1, Box 4, File 8.


Marion Royce, *Eunice Dyke*, p. 53,76.

Eunice H. Dyke, "The Organization of Public Health Nursing," read before the Canadian Conference of Charities and Correction, Ottawa, 1917, *CN* 14 (1918): 1017. Dr. Bryce was the President of the Conference and had been the first Secretary of the PBH, serving from 1882 to 1903. He was also the Secretary-Treasurer of the Association of Executive Health Officers of Ontario from 1886-96 and from 1900-1902. For a brief record of his accomplishments and career, see Heather MacDougall, "'Enlightening the Public': The Views and Values of the Association of Executive Health Officers of Ontario, 1886-1903," in Roland, *Health, Disease and Medicine*, p. 436-64.


*PBHAR*, 1919, p. 231.

C.-E. A. Winslow, *Evolution*, p. 55-56. For an informative discussion of British origins of public health nursing (called "health visiting") and the debate about its functions, see Celia Davies, "The Health Visitor as Mother's Friend."

Her biography will appear in my forthcoming monograph tentatively entitled *Marguerite Carr-Harris: The Biography of an Ontario Public Health Nurse*. The population and mileage estimates are taken from a hand-drawn map and notes in Carr-Harris's (hereafter C-H) own writing, to be found in AO, RG 10, 30A1, Box 1, File 14. As an indication of the vast distances involved, it took more than 18 hours to cross from east to west in District Seven by train.

For a description of the District, see a Ministry of Agriculture (Ontario) Pamphlet entitled "Northwestern Ontario, 1923," in AO, RG 10, 30a1, Box 1, File 14. A lengthy discussion of potential conflict with physicians is found in a typescript, "Proceedings of Meeting of the Provincial Board of Health, March 5, 1917," AO, RG 8, I-1-A-1, Box 64, p. 36-38.


A lengthy description of her visits to local dignitaries, i.e., the mayor, the doctors, and the ministers, is found in correspondence of C-H to Miss Power, 7 November 1920, AO, RG 62, Flb, Box 478. (Unless otherwise indicated, all correspondence from Kenora and Fort William is to be found here.) The description of distrust is found in C-H to Power, 2 November 1920; also see her letter of 7 November to Power in which she questions how the Victorian Order of Nurses and the PBH nurses will work together. The poverty is described in C-H to Power, 2, 7, 8 November 1920.

On breastfeeding, see the published work of Dr. Alan Brown, Chief of Pediatrics at the Toronto Hospital for Sick Children for 30 years, as well as the writings of Dr. Helen MacMurchy. For discussion of country physician's attitudes, see Nurse Edna Squires to Power, 14 August 1923, and C-H to Miss Knox, 10 December 1920. See also C-H to Knox 22 November 1920. Evidence that rural (and urban) physicians were unfamiliar with feeding infants and children is provided by Dr. Alan Brown, "Problems of the Rural Mother in the Feeding of Her Children," *CN* 14 (1918): 1160. Influenced by widespread commercial baby-food advertising, some mothers undoubtedly asked for formula feeding instructions.

"Report on Townships and Railways, Summer, 1923," p. 3, AO, RG 10, 30A1, Box 1, File 14 (all field reports are found in this source.) Whooping cough vaccine was available to private physicians by this date.


For the chronology of events, see letters between C-H and Power in April 1921. Evidence from other local sources about the wish to avoid taxes is lacking in my account of the happenings. Money does not appear to have been the biggest stumbling block, however. The town had a "current surplus" of $121,747.14. The nurse's salary and expenses would have been, at most $2,500.00 per year. Town of Kenora, "Financial Statements for Year Ending 1921," AO, RG 19, F4Cl, Box 194A, "Kenora, 1905-1931."

Unless otherwise indicated, information in this section is found in a typescript, "Report of the Demonstration of the work of a Public Health Nurse conducted by Miss M. R. Heeley at Bowmanville, Ontario, Sept. 8-Nov. 8, 1921." It consists of 19 pages of text, and includes snapshots of buildings and people, mostly women and children. AR, RG 10, 30A1, Box 1, File 12. Paradoxically, Marjorie Heeley Whitney does not remember writing this report and believes that some details are inaccurate. Interview, 15 September 1986.

Knox to Heeley, 12 December 1921. AO, RG 62, Flb, Box 473 (all of Heeley's correspondence is to be found in this source).

Heeley to Power, 5 January 1922. In actual fact, the town was not wealthy. Their yearly report for 1921 was not available; however, in December 1920, Bowmanville
reported a “town surplus” of $343.75 and a capital surplus of $29,848. Town of Bowmanville “Financial Statement,” 31 December 1920, AR, RG 19, F4C1, Box 33.

Daily Journal entry, 6 February 1922, Marjorie Heeley Whitney (hereafter MHW).

MHW to Power, 29 September 1922.

Interview with MHW, 16 September 1986. Also personal telephone conversation, November 1986. The salary ($1,500 per year) was superior to most other nursing jobs; the perks included the use of a motor car and the prestige of the job.

PBHAR, 1920, p. 25.

Untitled, undated typescripts (about 1924), P. 2. AO, RG 10, 30A1, Box 8, File 15. It begins: “The Division has been operated as at present organised for three years...”


Untitled, undated (about 1924), p. 3.

Untitled, undated (about 1924), p. 4-6.


“General Report of Work... in District No. VII,” p. 4. Many of the nurses’ names became “household words.” See, for example, a mention of PHN Rose Hally, in Alice Marwick, The Northland Post: The Story of the Town of Cochrane (Oshawa: Maracle Printing Co., 1950), p. 261. Carr-Harris’s files contain some letters from mothers and children indicating she was a friend and source of help to them.