The Right to the Best Medical Care: Dr. W. P. Warner and the Canadian Department of Veterans Affairs, 1945-55*

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Abstract. Dr. W. P. Warner was appointed as the first Director General of Treatment Services of the Canadian Department of Veterans Affairs, in March 1945. Prior to his appointment, Warner had been the Deputy Director General of Medical Services in the Royal Canadian Army Medical Corps (RCAMC). During his 10 years as Director General, Warner dramatically re-organized Treatment Services to ensure the right of every disabled veteran to "the best medical care." To meet this goal he drew on his experience in academic and military medicine and established new links between Canadian faculties of medicine and veterans medical services. Physicians, involved in diagnosis and treatment, were employed on a part-time basis and held university appointments. Postgraduate and undergraduate teaching programs for physicians and other health professions were established. Professional Consultants and Medical Advisory Committees were developed to provide advice on all aspects of medical care. Finally, medical research and new clinical investigative units were established in Canadian veterans' hospitals. As a result of Warner's new policies, academic medicine was placed in the forefront of veterans medical services and developed the first national model for the integration of medical care, education, and research in Canada. Indeed, many current Canadian practices in medical care, education, and research can find some of their roots in the policies and programs of Treatment Services that began in 1945 under Warner's leadership.

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Résumé. En mars 1945, le docteur W. P. Warner fut le premier directeur général nommé aux services de traitement du Département canadien des anciens combattants. Avant d’être nommé à ce poste, Dr Warner occupait le poste de député du directeur général des services médicaux du Corps médical de l’armée royale du Canada (CMARC). Tout au long de son mandat (qui dura 10 ans) en tant que directeur général, le Dr Warner élabora des réformes radicales dans les services de traitement, afin d’assurer à chaque vétéran handicapé le droit aux «meilleurs soins médicaux». Pour atteindre ce but, il se servit de son expérience médicale acquise tant dans le milieu académique que militaire et créa de nouveaux liens entre les facultés de médecine canadiennes et les services de traitement dispensés aux anciens combattants. On vit des médecins spécialisés dans les diagnostics et les traitements, employés à temps partiel tout en occupant des postes universitaires. Il mit sur pied des programmes d’enseignement de premier cycle et de troisième cycle pour les médecins et autres professionnels de la santé. Il forma des comités composés de consultants professionnels et de conseillers médicaux dans le but de procurer des conseils sur tous les aspects des soins médicaux. Enfin, il établit de nouvelles recherches médicales et des champs d’investigation clinique dans les hôpitaux d’anciens combattants. Grâce aux politiques du Dr Warner, la médecine en milieu académique fut au premier plan des soins médicaux dispensés aux anciens combattants et le premier modèle national canadien où l’on intègre soins médicaux, enseignement et recherches. En vérité, plusieurs des pratiques médicales qu’on retrouve de nos jours en médecine, en enseignement et en recherches au Canada remontent aux politiques et aux programmes des Services de traitement entrepris en 1945 sous la direction du Dr. Warner.

War and medicine have often been linked to changes in civilian medical practice. However, the impact of veterans' medical care on the practice of medicine has not been studied as extensively. In Canada, following World War II, the Canadian government passed a comprehensive set of new legislation, called the Veterans Charter, for the rehabilitation and re-establishment of all war veterans. The Veterans Charter, often considered one of the most comprehensive pieces of veterans’ legislation in the world, offered a wide range of benefits and services to re-establish over one million Canadian veterans back into civilian life.

A new Department of Veterans Affairs, established in 1944, was responsible for all veterans’ services. Medical care for veterans was provided through the Treatment Services Branch. Dr. W. (Bill) Warner, Deputy Director General of Medical Services in the Royal Canadian Army Medical Corps (RCAMC), was appointed the first Director General of Treatment Services in March 1945. Warner drew on his past experiences in academic and military medicine and established new methods for medical care for Canadian veterans. During his 10 years as Director General (1945-55), Warner developed five main policies which he believed would ensure the right of every disabled veteran to “the best medical care.” These policies were the recruitment of part-time physicians holding university appointments; affiliations with all Cana-
dian Faculties of Medicine; introduction of undergraduate and postgraduate education for physicians and other health professions; appointment of new Professional Medical Consultants and Medical Advisory Committees; and the introduction of funding for medical research and new clinical investigative units in veterans' hospitals.

Warner dramatically changed the delivery of medical care for veterans and developed the first national model for the integration of medical care, education, and research in Canada. This article describes and analyzes the impact of veterans' medical services, under Warner's leadership, on the development of medical care, education, and research in postwar Canada.

EARLY PLANNING FOR VETERANS' MEDICAL SERVICES, 1939-44

Following World War I, the Canadian government was one of the first governments to provide medical care, rehabilitation, vocational training, and pensions for disabled veterans under the Department of Soldiers Civil Re-establishment (DSCR). The Canadian programs focused on medical treatment, early "retraining for those who were handicapped for their pre-enlistment occupation," placement in employment, and the provision of medically assessed pensions for disability. Retraining was to return the disabled veteran to the level of pre-enlistment occupation and not designed to improve his level of education or training. However, despite the early successful examples of rehabilitation and retraining programs for disabled veterans, the DSCR programs were gradually phased out in the early 1920s.

Declines in the Canadian economy between 1920 and 1921 and the Depression in the 1930s led to unemployment and poverty among older and disabled veterans. Inadequate disability pensions forced many veterans to turn to the government for financial assistance. Various measures, including the War Veterans' Allowance Act of 1930, and the Veterans' Assistance Commission, established in 1936, were developed to provide support for unemployed aging and disabled veterans. Despite these measures, unemployment and poverty among aging and disabled veterans did not decline until the outbreak of World War II.

Disabled veterans, unable to live in their communities, were cared for in hospitals administered by the Department of Pensions and National Health (DPNH). In 1921, 5,000 veterans received treatment. At the outbreak of World War II, in 1939, DPNH operated eight hospitals across Canada and provided medical care in hospital for 2,224 World War I veterans.

The Canadian experiences in the re-establishment of World War I veterans had a direct and major impact on planning for re-establishment for World War II veterans. Many of the early planners, such as Walter S.
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Woods, the former Chairman of the War Veterans' Allowance Board, were veterans of World War I. Woods, who played a leading role in the development of veterans' programs between 1930 and 1950, summarized his feelings as he joined the planning process:

On September 10, 1939, less than twenty-one years after the Armistice of World War I, we were plunged into another. We had just had time to raise and prepare another generation for the slaughter—a generation largely made up of the sons of those who fought in "the war to end wars." Is it any wonder that many of us who had been engaged in trying to repair the damage done in the lives of veterans of 1914-1918, and now found ourselves involved in another war, were sick at heart? A war—not of our seeking—but one in which we had to stand and fight for all we believed in—or perish along with freedom from the face of the earth.  

On 8 December 1939, the Canadian government established a Special Cabinet Committee on Demobilization and Re-establishment with the Minister of Pensions and National Health, Ian Mackenzie, as Chairman. The Committee established an Inter-departmental General Advisory Committee, consisting of senior members of the Civil Service. Brigadier-General H. F. McDonald, Chairman of the Canadian Pension Commission, was appointed chairman, and Walter S. Woods, Chairman of the War Veterans' Allowance Board, was appointed as vice-chair. The Committee addressed all aspects of the question "What does the country owe to those who, forsaking everything, offered their lives in its defence—to try and compensate for the time that was lost, and the opportunities that were missed."  

Medical treatment for veterans discharged from the armed forces between 1939 and 1944 was provided by staff in the Medical Services Branch of the DPNH, sometimes called the "department of pain and no help." Recruitment of new medical staff equipped to deal with the care of young veterans was difficult. Many of the senior medical leaders from Canadian universities had enlisted in the medical services of the armed forces at the outbreak of the war. They were based in Canadian military hospitals in England or on the battlefields of Europe. In addition, many medical students enlisted in the armed forces and following graduation, were posted into hospitals operated by the DND in Canada or overseas, thus limiting the number of newly trained young physicians available to staff DPNH hospitals. During World War II, there were 5,219 medical officers, 4,172 nursing sisters, and 40,112 in other ranks in the medical services of the three Armed Forces in the Canadian Department of National Defence.  

Physicians working in DPNH were hired on a full-time basis through the Canadian Civil Service Commission. Many of the medical and nursing staff were veterans of World War I who had remained with the de-
partment providing care to these veterans. Initial planning for medical care for World War II veterans focused on the expansion of existing DPNH hospitals and the short-term use of civilian hospitals. Plans for expansion of hospital beds, however, were hindered by conflicts over responsibility for medical care of members of the armed forces in Canada between senior staff in the DND and the DPNH.

In September 1939, Dr. Robert Wodehouse, the Deputy Minister of DPNH, argued that hospital treatment or institutional care for members of the armed forces in Canada "be carried out under the control and management of the Department of Pensions and National Health." Wodehouse was successful in gaining control in the early years of the war; however, the armed forces expressed great concern that civilians were given responsibility for armed services personnel. By 1941, "the duty of taking medical and hospital care of all men in our military forces until such men are placed in Category 'E'" was given to the DND. The number of hospital beds in Canada under the control of the armed services grew from 420 in 1939 to 13,057 in 1944. Construction of hospital beds for DPNH progressed at a much slower pace, growing from 2,595 at the outbreak of the war to 7,244 operating beds.

Soldiers returning to Canada often reported poor conditions in the DPNH hospitals, particularly the Christie Street Hospital, in Toronto, which was the main Canadian veterans' hospital. Complaints about poor quality of care and overcrowding became commonplace by 1944 as the growing number of casualties returning from overseas taxed the system. The example of Fred Woodcock, who lost his sight during the Dieppe raid in 1942, and who spent over a year as a prisoner of war in Germany before being repatriated to Canada, seemed to have been a common one. He recalled his experiences at Christie Street Hospital in Toronto:

Christie Street is where I was operated on the first time. . . . I remember lying on the top floor, . . . they were going to put a new roof on, and there was just open boards up there and the dirt falling on us. . . . That's when the ladies in Toronto got up in arms and they built Sunnybrook. . . . They were disgusted at the set-up we had.

Community leaders, families, and members of veterans' associations were strong advocates for improved medical treatment for veterans. Dr. Minerva Reid of the Toronto Women's Committee wrote to Mackenzie that "the building is old, cockroach-infested and rat-ridden, and sick and wounded men are suffering there needlessly." However, improvements in medical services in DPNH continued to be limited by the ongoing conflicts between the staff of the DND, and the staff of the DPNH over responsibility for building and administering hospitals for veterans. These conflicts reached a peak in 1944, when James L.Ral-
ston, Minister of National Defence, joined the criticism. In a letter to Mackenzie, he wrote that "D.P. & N.H. are responsible for taking over from Army all cases where treatment will not, within a reasonable time, render them fit for duty... I fear that D.P.&N.H. do not realize the magnitude and the urgency of the problem and are depending on hospitals which will not be constructed for many months." 

Initially, Mackenzie defended the members of his department. However, by June 1944, Mackenzie was frustrated by his senior bureaucrats, who seemed more concerned to protect their hospitals from encroachment by DND than improving their own medical services for returning veterans. In a response to a memo from Deputy Minister Wodehouse, Mackenzie wrote: "The important question is—Have we enough beds? It does not matter whether it is a Defence responsibility or D.P.& N.H. but it is vital that enough beds are ready or in sight." 

In response to growing concerns about the plight of Canadian veterans, Prime Minister Mackenzie King agreed to support a proposal from the Canadian Legion to establish a new department to "be responsible for the administration of all legislation benefiting veterans of all wars relating to their rehabilitation to civil life, their hospitalization, and their social security and future welfare." On 13 October 1944, Ian Mackenzie was appointed the first Minister of Veterans' Affairs. Wodehouse, the long serving Deputy Minister of DPNH, moved to the Canadian Pension Commission. In his place Mackenzie appointed Walter Woods, the former Associate Deputy Minister in DPNH. Woods was an ardent proponent of veterans' services and wrote that in planning: "It is not a question of How little can we get away with? but How much do we owe?" 

One of Mackenzie's first actions as Minister was to ask the new Minister of National Defence, Andrew G. McNaughton, in January 1945, to second Brigadier-General W. P. Warner, Deputy Director General of Medical Services (Army) to:

Make a survey of the entire hospital situation and let me have the benefit of his observations and recommendations for the correction of any situation that may emerge [because both] the patient strength in Great Britain, the expected casualties, the full utilization of the hospital facilities both in Canada and abroad are involved, this survey could be made with greater facility by a senior Service officer than by an officer of this Department.

During World War I Warner had interrupted his medical education at the University of Toronto to serve as a Surgeon-Probationer. He subsequently graduated in medicine in 1920 and spent four years in postgraduate study as the first postgraduate resident of Dr. Duncan Graham in the Department of Medicine at the University of Toronto. Graham was the first full-time Professor of Medicine appointed in the
British Commonwealth and was one of the leading physicians in the development of postgraduate medical education and medical research during this period.\textsuperscript{26}

Warner resigned his residency position in 1924 after developing tuberculosis. Following two years of treatment, he practised medicine briefly in a clinic in Welland, Ontario and returned in 1929 to join the staff of the Department of Medicine, University of Toronto, and the medical service of the Toronto General Hospital. Warner received his Fellowship in the Royal College of Physicians and Surgeons in 1931; by 1939, he was an Associate Professor and Senior Attending Physician (Medicine) at the Toronto General Hospital. Warner was considered "a good teacher with a particular flair for stimulating interest and thought. The soundness of his ideas and his imagination in coordinating facts earned him the high regard of his colleagues."\textsuperscript{27} Warner's medical practice and research was in the area of pulmonary diseases, particularly bronchiectasis and lung abscess.\textsuperscript{28}

At the outbreak of the war, Warner joined the Royal Canadian Army Medical Corps (RCAMC) as Officer-In-Charge of Medicine in No. 15 Canadian General Hospital. His mentor, Dr. Duncan Graham, was also appointed in 1939 as consulting physician to the Director General of Medical Services of the Army. Warner was invalided home in June 1940, but continued to serve in the RCAMC, first, as Consultant in Medicine, and later as Deputy Director General of Medical Services (Army) with the rank of Brigadier-General.

Warner's survey report, finished in February 1945, drew intense criticism from some sectors of the Department. One anonymous senior bureaucrat, in an extensive confidential memorandum to Mackenzie, argued that:

A majority of the proposals are illegal, contrary to well established Government policy, or impracticable. They appear to be prompted by regard for the medical profession, the medical faculties of the universities, the Army Medical Corps and the Canadian Medical Association. There is hardly one suggestion that seems to have been inspired by consideration for the welfare of the patients in the hospitals... the intervention of the universities runs counter to sound organizational principles. The filling of positions in the Department by seconding persons from the armed forces is also contrary to good organization.... The Department's real weakness is in prestige, rather than in performance. Our medical officers seem not to belong to the aristocracy of the medical profession. They have worked unselfishly for the patients and not for the profession.... The Department does need a more showy facade on the medical side. But, it should be obtained from our own resources and not by permitting the Department to be infiltrated with self-seeking medical aristocrats [emphasis added] from other organizations... quite frankly, I am sceptical of Brigadier Warner's theory that all our problems can be solved by loaning and seconding Army personnel.... I suspect it of being a further effort to ease the Army into control of this Department.\textsuperscript{29}
Mackenzie rejected this advice and appointed Warner as the first Director-General of Treatment Services in March 1945. The Minister, in announcing the appointment, called Warner an expert in “methods of handling all types of casualties all the way from the battlefield to Canada.” Woods, the Deputy Minister, later wrote that Warner’s experiences in academic and military medicine made him “uniquely qualified to organize a treatment service for veterans in accordance with the best principles of the modern practice of medicine. His professional standing was such that he was able to attract the most outstanding medical men in the Dominion to assist him in his task.”

TREATMENT SERVICES: IMMEDIATE EMERGENCY REORGANIZATION

To meet the needs of the rapidly increasing number of returning soldiers and prisoners of war, Warner developed a two-phase approach: immediate emergency reorganization followed by development of long-term policies. This first phase, Immediate Emergency Reorganization, addressed the initial expansion of staff and facilities. Warner recognized that these early increases would be temporary and demand for service would decrease quickly as veterans completed treatment and returned to civilian life. Long-term policies would be needed, after the initial build-up of services, to address ongoing medical needs of veterans and future developments in veterans’ legislation which could change entitlements for medical services.

The scope of these early tasks was daunting. By October 1946, 343,000 servicemen had been repatriated from overseas, and a total of 713,000 servicemen were demobilized. Included in these figures were over 29,000 veterans reported as seriously disabled. In 1939, DPNH hospitals had 2,224 in-patients. This figure grew to over 16,000 by 1946, and fell to 11,000 by 1949—almost equally divided between World War I and II veterans. Hospital admissions for 1946-47 reached 134,666.

During the war years, the cabinet of Prime Minister Mackenzie King had been developing plans for the establishment of a national health insurance program that would fund basic medical services for all Canadians following the war. These initiatives, discussed at the 1945 Dominion-Provincial Conference on Reconstruction, failed due to conflict over federal-provincial jurisdictions. Veterans’ medical services, fully under the jurisdiction of the Mackenzie King government, provided an opportunity to develop a model of a national health system. In October 1945, the Minister of Veterans Affairs reported to Parliament that the Department was “giving a modified health insurance service to more than 650,000, or approximately one-third of Canada’s male working population.”
The Veterans' Charter provided medical treatment for: veterans with income less than $100 a month; veterans who incurred a disability within a year from discharge; and veterans involved in training or education programs sponsored by the Department. Treatment also was provided to all veterans, during the first year following discharge, called the Rehabilitation Class, to ensure that the re-establishment of the veteran into civilian life was not hampered by having to pay the costs of treatment for illness or accidental injury. In the immediate postwar years, staff levels in Treatment Services grew from 4,179 in 1945 to peak at 11,801 in 1947 and decreased to 9,253 in 1951.

Warner's first policy initiatives addressed recruitment of staff and expansion of bed space. Two new policies were developed to recruit physicians into Treatment Services: the use of part-time appointments and the development of a Doctor of Choice Plan. Beginning in 1945, physicians involved in diagnosis and treatment were employed on a part-time, sessional basis. Warner argued that sessional physicians who worked "on a half day fee basis... should devote time not spent in departmental work to work in the medical faculty of a University, in private consulting practice, in their general practice or in taking postgraduate work at the University." Thus, physicians could be employed, for limited time periods, without long-term commitments, which facilitated the Department's expansion and its contraction after 1947 as demand for medical treatment declined.

Warner moved the recruitment process for physicians from the control of the Civil Service Commission, which had hired physicians for the DPNH, to Treatment Services. A small advisory committee of senior academic and military medical leaders was established to advise him on recruitment. The group, consisting of Brigadier J. A. MacFarlane, formerly Consultant in Surgery to the Canadian Army Overseas, Wing Commander R. F. Farquharson, Consulting Physician, and Wing Commander Gilbert Adamson, Consulting Psychiatrist for the Royal Canadian Air Force, travelled across Canada to study the need for professional help in the DVA hospitals and the availability of physicians. They consulted with the Deans of the Faculties of Medicine and developed lists of appropriate part-time physicians for recruitment. Warner's change in the recruitment process allied the Department closely with academic medicine, something he would continue to do as he developed Treatment Services in the coming decade.

The use of part-time appointments allowed many physicians, who had worked on the battlefield or in military hospitals in England, an opportunity to provide medical care to veterans while maintaining their old university appointments. It also offered them a way to gradually re-enter civilian medical practice. For example, Dr. E. Harry Botterell had
been in charge of neurosurgery at No. 1 Canadian Military Hospital at Basingstoke, England. In January 1945, he returned to Christie Street Military Hospital and found that:

It was a very traumatic experience. . . . They’d all come through my service [at Basingstoke] . . . it was traumatic because I came from a really high-class operation—medical, surgical, x-ray, every way you could think of. . . . and to come back to a hospital that wasn’t ready. . . . Bill Warner hadn’t got his reorganization through yet. . . . this was an old quiet pension hospital, being asked to care for scores of casualties. . . . There was a committee in Ottawa. . . . responsible for the special units, neurosurgery, orthopaedic surgery, plastic surgery, across Canada. I wrote my first monthly report to this committee. I was aghast at what I found. . . . I took it down to Arthur Norwich [Medical Superintendent] and said, “Arthur can I send this off to this committee with your blessing?” He sat down and read it, and said, “Harry, I’ve been telling them that for months. It isn’t strong enough.” “Well,” I said, “I can’t think of anything any stronger.” So down I went to Ottawa, to defend this report. . . . We got more nursing service, more orderly service, a new diet, and new physiotherapy, new everything. We started from scratch.40

Warner was the first to use part-time physicians with university appointments in veterans medical care in Canada. It followed closely his experience in the RCAMC where close links between academic medicine and military medicine had developed during both World Wars.41

The Doctor of Choice Plan, the second aspect of Warner’s recruitment plan, provided payment to physicians providing care to veterans living in areas where there were no DVA facilities. Payments were based on a schedule of fees, developed in consultation with the Canadian Medical Association. The Doctor of Choice Plan allowed “veterans requiring treatment, who were resident in communities without a veterans hospital, to choose their own physician except for certain specialized forms of treatment.”42 Previously, veterans could only receive treatment from a physician hired by the Department. The Doctor of Choice Plan decreased the demand for medical services in veterans’ hospitals and the need to rapidly build new hospitals. In addition, it provided a mechanism to increase the number of physicians, including former medical officers, able to provide care to veterans.

To expand bed space Warner established new collaborative arrangements with his former colleagues in DND to take over their active treatment beds as they became available.43 A total of 22 military hospitals were transferred to Veterans Affairs to meet the initial influx of returning ex-servicemen. By 1949, only five were still in operation due to the decline in patient population, replacement by new facilities, and provision of medical care in veterans’ wings in civilian hospitals. Warner’s strategy provided access to the needed bed space but avoided a major building program during the immediate postwar period when con-
struction was difficult due to wartime shortages and long-term predictions were uncertain.

After the initial transfer of facilities from DND, Veterans Affairs administered four types of facilities: active treatment hospitals; Health and Occupational Centres; Special Treatment Centres; and Veterans' Homes. Active treatment hospitals were spread across Canada and offered a full range of medical and surgical treatment. Two new active treatment hospitals were opened in 1948: Sunnybrook Hospital replaced the aging Christie Street Hospital, and Camp Hill Hospital opened in Halifax.44

Health and Occupational Centres, developed during the war to provide for convalescence before a soldier returned to his unit, were maintained to provide for convalescence for veterans prior to returning home. These centres were located in attractive settings, away from a hospital atmosphere, with a planned program including group exercise, sports, and handicrafts, so that on discharge, veterans have "recovered to the point where they can resume their normal employment."45 The centres, along with the other new Special Treatment Centres, were the first rehabilitation centres in Canada and provided a model for civilian rehabilitation centres which developed in the late 1950s.

Eight new Special Treatment Centres were developed to provide programs for specific medical conditions. These included four new centres for treatment of spinal cord injury, in Toronto, St. Anne de Bellevue, Quebec, Winnipeg, and Vancouver.46 These were among the first facilities in the world to provide rehabilitation for spinal cord injury. Special centres were also developed for neuropsychiatric conditions, tuberculosis, and arthritis.47 Finally, Treatment Services administered seven Veterans Homes for aging World War I veterans who required domiciliary care. Like the special centres, the Veterans Homes became a base for new developments in the emerging field of geriatric medicine in the 1950s.

LONG-TERM POLICIES: INTEGRATION OF MEDICAL SERVICE, EDUCATION, AND RESEARCH

By 1950, Warner had established five central policies for Treatment Services: continued use of part-time medical staff; university affiliations; professional education; use of professional advisors and medical advisory boards; and the establishment of research within Treatment Services facilities. The use of part-time medical staff became the cornerstone of the medical staffing policy of Treatment Services. Physicians involved with diagnosis and treatment were drawn from members of the Faculties of Medicine in the district where a veterans' hospital was situated. Warner wrote:
These part-time specialists are the mainspring of treatment services. They represent, I believe, the finest in Canadian medicine. They usually teach part-time in a civilian teaching hospital and carry on a limited consulting practice. While those specialists who were demobilized from the Services found their employment with the Department a very desirable rehabilitation measure to get them re-established in their special practice, they have, by and large, continued to serve the Department and now in 9 cases out of 10 at a financial loss to themselves.48

A small number of full-time appointments were maintained in DVA hospitals for departments which required an administrative as well as a clinical component, such as radiology, anaesthesiology, and laboratory medicine; however, the largest category of appointments were part-time. In 1949, Warner reported that of the 1,005 physicians employed by the Department, only 173 were full time, while 832 medical staff, an overwhelming majority, were part-time.49

Members of Canadian Faculties of Medicine had been actively involved with military medicine throughout World War I and II. However, until Warner's appointment, no formal affiliations had been developed between the veterans' medical services and the Faculties of Medicine in Canadian universities. Warner had a strong belief in the importance of links with the university for maintaining excellence in medical care. Beginning in 1945, he developed affiliations between Treatment Services, departmental hospitals and Faculties of Medicine across Canada. These links grew naturally out of Warner's previous experience in the Armed Services where many senior members of the Medical Corps had left university positions to serve during the war. For example Warner's former chief, Brigadier-General John Meakins, Deputy Director-General Treatment Services between 1942 and 1944, was Dean of the Faculty of Medicine at McGill University.

The development of university affiliation and co-operation with Treatment Services provided a new opportunity for national collaboration on medical issues between Canadian Faculties of Medicine and the Department. This was unique in Canada since hospitals were under provincial jurisdiction and few forums existed, during this period, for discussion of medicine on a national basis. Warner argued that because of:

Our present arrangements with the universities and medical specialists, a better standard of treatment would be difficult to secure. The standard has been made possible by the active co-operation of the medical profession of Canada, along with the medical faculties of the universities . . . for the best medical treatment procurable in Canada, in my opinion, is the right of every disabled veteran.50

The use of part-time specialists holding university appointments also was linked directly to the establishment of medical education within
departmental hospitals. An October 1945 departmental press release stated that the appointment of physicians with university teaching appointments would enable the department’s hospitals to begin to provide education for residents and interns. Warner, a former Associate Professor of Medicine, believed that:

Where either post-graduate or undergraduate teaching is being done in a hospital, it is a great incentive to good Medicine. . . . co-operation between universities and the Department has been of great mutual advantage to both parties and has been the greatest single factor making it possible for the highest type of medical care for the veteran.

Not everyone agreed with the development of departmental hospitals as teaching hospitals. The 1950 annual meeting of the Canadian Legion heard complaints about poor quality of care resulting from the introduction of medical education. “The use of departmental hospitals for teaching purposes has brought with it some of the methods and stigma attaching to the treatment of pauper patients in public wards of civilian hospitals.” These comments were based on the prevailing use of charity patients for medical education during this period. Indeed, Warner was among the first in Canada to link the quality of medical practice to the presence of medical education.

In the postwar era, these new teaching programs, provided in veterans’ hospitals, were important as postgraduate medical education expanded rapidly between 1945, when 23 physicians successfully completed fellowship, to 1955 when 486 physicians obtained their fellowship or certification. Physicians who had been medical officers in the armed forces were eligible for funding for postgraduate education and for the Veterans’ Preference in applying for admission to these programs. This was important as many Canadian medical students had gone through accelerated medical education programs to enable them to enlist during the war. The additional opportunities for postgraduate training offered them a period of time to upgrade skills and return to civilian practice. Funding was provided for retraining both in Canada and other countries. In addition, veterans who wished to pursue a new career in medicine following the war were provided with funding for their professional education under the Veterans’ Charter.

Many of Warner’s initiatives in Treatment Services were drawn from his past experiences in academic and military medicine. This was certainly the case in the recruitment of professional advisors and the development of a new administrative structure for Treatment Services. In 1942, the RCAMC had established a medical consultant service and appointed prominent physicians, usually drawn from Faculties of Medicine, to improve the quality of medical care. Consultants were appointed in medicine, surgery, psychiatry, gynaecology, chemical warfare, and
laboratory medicine. Warner developed the same administrative structure as the RCAMC and established professional and administrative branches in Treatment Services. A central administrative staff, based in Ottawa, dealt with hospital accommodation, equipment, development, and planning. Advice on professional issues was provided by practising consultants with university appointments, who were appointed as Professional Advisors to the Department. Warner argued that: "How medicine should be practised can best be determined by the highest skilled specialists whose integrity and professional skill reflect the best in Canadian medicine . . . this advice comes not from full-time Government employees but from the best of our university staffs and profession in Canada."

In 1947 Warner established a new national Medical Advisory Committee for DVA. Members of the Committee were drawn from leaders in academic medicine from across Canada. The Committee advised the Department "regarding general policy in the medical treatment of veterans, particularly in relation to the calibre of the medical men employed and the type and character of treatment provided . . . the present excellent University—D.V.A. co-operative relationship and the administrative functioning of the Doctor of Choice Plan."

New medical advisory boards also were established in departmental hospitals. These corresponded to medical advisory boards in civilian hospitals and comprised the heads of medical services and departments plus elected members from the consulting staff. The chairman was elected from among the membership. The advisory boards allowed physicians to provide advice "that carries great weight in what goes on in hospital . . . a means of making advice on policy and local arrangements the responsibility of local medical authorities."

All three of Warner's initiatives to provide professional advice from outside of the department were new in the field of veterans' medical services. The Department of Pensions and National Health, which had administered medical programs for veterans prior to 1945, had employed only full-time physicians hired through the Canadian Civil Service Commission. Warner argued that the use of advisory committees and professional advisors, linked to academic medicine, enabled him to "run the medical service on the advice of the most competent practising and teaching physicians in the country."

Warner's final policy initiative was the introduction of medical research into Treatment Services. During Warner's career as a member of the Faculty of Medicine, he had developed a strong respect for the linkage between research, clinical practice, and education. In the period between the two World Wars, the University of Toronto had become a major centre for medical research. Indeed, North America's first Nobel
prize in medicine had been awarded to Frederick Banting and John McLeod for the discovery of insulin while they were members of the Faculty of Medicine of the University of Toronto.61

Early medical research in Treatment Services focused on antibiotics, the development of rehabilitation for spinal cord injury, electric shock, and insulin and sub-insulin shock therapy, the use of curare in anaesthesia, and development of prosthetics.63 By 1950, a grant of $300,000 was awarded by the Privy Council Committee on Scientific and Industrial Research to develop a program of medical research and education. This annual grant continued throughout Warner’s tenure at Treatment Services. In 1953, the grant was approximately $350,000 and 112 persons were employed on research activities within the Department.64 A special medical advisory committee used this funding to support the development of specialized Clinical Investigative Units as well as to support individual research projects.

The Clinical Investigative Units were developed in each of the departmental hospitals to evaluate clinical practice and act as “spark plugs” for research in hospitals. The departmental hospitals provided unique opportunities for clinical research in Canada. As one researcher noted:

The Special Treatment Service Centres of the Department of Veterans Affairs offer an excellent opportunity to carry out studies on selected series of cases for several reasons. Complete and continuous records, including service documents and previous histories, are available on all patients. In addition, the personnel concerned in the investigation recorded a standard history and examination. The patients had a similar background, as almost all of them were healthy young males, who had previously been considered fit for active service. They were under no economic strain during investigation and treatment, and conservative measures could be given a thorough trial. Excellent facilities were available for physiotherapy and physical training.65

Under Warner’s leadership, Veterans Affairs became one of the main funding sources for medical research in Canada during the postwar years.66 Research activities were reported in medical journals in Canada and other countries as well as in the Treatment Services Bulletin (later called Medical Services Journal, Canada) the official journal of the Department. A sample of articles reporting on research activities for the period 1945-55 shows a wide range of activities with a major focus on clinical research, particularly in the newly developing areas of rehabilitation and geriatric medicine.67
VETERANS’ MEDICAL SERVICES IN THE UNITED KINGDOM AND THE UNITED STATES

Medical care for Canadian veterans influenced and was influenced by developments in other countries, particularly the United Kingdom and the United States. The members of the General Advisory Committee on Re-establishment had reviewed the report, *Social Insurance and Allied Services*, by Sir William Beveridge, which laid the groundwork for a national health service in the United Kingdom which would serve both veterans and civilians.68 Warner visited England in 1947 to review the medical treatment being provided to Canadian pensioners in the United Kingdom and Europe. While in England he studied the new, 1947 *Health Act* for provision of state medical services for both civilians and veterans. His report of the visit focused particularly on changes in medical education. He wrote that the policy of "having Universities and University teaching hospitals the pivot point about which the health scheme works, augurs well for the future. This policy has been formulated to increase the efficiency of the medical services provided, and also to prevent what is feared by many, that the state employed doctor will lose professional interest and ambition."69

Warner did comment favourably on the policy of providing federal funding for postgraduate students, during their training, and the central role given to the university in supervising postgraduate medical education.70 Warner did not, however, comment, in this report or later reports on his views about the integration of civilian and veterans’ medicine in the United Kingdom.

In the United States, the Veterans’ Administration had been established in 1931 to consolidate all aspects of veterans services. All employees, including physicians, were hired through the Civil Service Commission. Veterans’ Administration officials had studied the Canadian legislation for rehabilitation and re-establishment of veterans, which was in place before Pearl Harbor. Indeed, as Woods later argued, "the G. I. Bill of Rights in the United States reveals a striking similarity to Canada’s Veteran’s Charter."71

Initial planning for veterans’ medical services in the United States had called for an ongoing expansion of existing veterans hospitals with medical services provided by physicians employed through the Civil Service Commission. However, as in Canada, these plans were to be changed in response to complaints about poor quality of veterans’ medical care. In August 1945, General Omar Bradley was appointed as Administrator to revamp veterans’ services. He appointed General Paul Hawley, formerly Surgeon General for armed forces in Europe, head of the Veterans Administration Medical Department. Under his new motto, “Medical Care Second To None,” Hawley established a new De-
partment of Medicine and Surgery to separate medical services from construction and supplies and appointed Dr. Paul Magnuson to head the medical services department. In 1946, Magnuson, with Bradley's and Hawley's full support, established new affiliations between veterans' medical services and medical schools. Dean's Committees, composed of members of local Faculties of Medicine, agreed to recruit, staff, and manage Veterans' Hospitals, outside of the Civil Service Commission, with physicians who held university appointments. New programs for medical education were introduced to veterans' hospitals and new funding for medical research was provided. Opposition to these changes was intense in the United States and after the departure of Bradley and Hawley, Magnuson was later fired. However, subsequent congressional hearings on veterans' medical care maintained the Dean's Committees and affiliations between veterans' medical services and Faculties of Medicine continued. In addition, as in Canada, research and medical education, introduced by Magnuson to veterans' hospitals, became a central part of veterans' medical services following World War II.

CONCLUSION

At the end of World War II, Canadians were agreed on the importance of providing outstanding medical care to all returning veterans. Bill Warner used this support to bring physicians from the fields of academic medicine and military medicine into the care of veterans. He placed academic medicine at the forefront of decision making in the provision of medical services to Canadian veterans. While Warner never returned to teaching at the University of Toronto, his accomplishments at Veterans Affairs laid a foundation for the ongoing growth of academic medicine in postwar Canada.

Warner believed that "the best medical care in Canada" could be provided for Canadian veterans through the development of a new national model of health care that integrated clinical practice, medical education, and research. To provide a foundation for this new model he formed a strong liaison between veterans' medical services and Canadian Faculties of Medicine. Warner's visions of the importance of the integration of clinical practice, medical education, and research, which is today accepted as a basis for good medical practice, was new in postwar Canada. Indeed, recent reports calling for the development of Academic Health Sciences Centres can find their roots in Warner's pioneering work in establishing the linkage between medical care, education, and research within Treatment Services. Warner told colleagues that:
I believe that the greatest single factor which can beneficially affect the ideals and ethics of doctors is the University from which they graduate. This influence should continue uncorrupted after graduation and be maintained by those of us in Federal Medical Services for the good of the profession as a whole, for our own good and ultimately for the provision of good medicine to our patients.\(^ {76} \)

Warner died in December 1955, at age 59, while still in office. In describing Warner, following his death, Dr. R. Ian MacDonald, a colleague from the University of Toronto, wrote:

Dr. Warner's life was one of the most useful in the records of Canadian medicine. . . . Despite the importance of his contributions to clinical medicine and to the RCAMC his greatest achievement was as Director General of Treatment Services. His ideas and ideals of what a great hospital service should be and the principles upon which he established it, will endure and will be of great help in future planning for efficient distribution of medical care for civilians and veterans alike. His exceptional ability to bring together people with conflicting ideas and interests to work towards the common good will long remain an ideal for Canadian doctors.\(^ {77} \)

NOTES

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4 Initial employment rates were impressive with 67.94% reported employed as trained, 22.26% employed otherwise, and only 5.74% unemployed in mid-1919 (Morton, *Winning the Second Battle*, p. 136-42, 202-25).

5 In 1921, the Canadian government provided relief for pensioners with less than a 30% pension because "these pensioners, having honourably served in the war and having fallen into destitute circumstances, should be relieved from actual want" (J. D. Hyndman, C. B. Price, and W. S. Woods, *Unemployment of Ex-Service Men* [Ottawa: J. O. Patenaude, 1935], p. 9). The War Veterans Allowance Board was established under P.C. 2280, 30 September 1930; Veterans' Assistance Commission was established under P.C. 1862, 17 July 1936.
6 Woods, Rehabilitation, p. 321. The DPNH was established in 1928.
8 P.C. 40684 is reproduced in Appendix D, England, Discharged, p. 393-94.
9 England, Discharged, p. 73. Subcommittees were formed to address Employment, Retraining of Special Casualties, Vocational Training, Post Discharge Pay, Special Problems of Discharged Women, Reconditioning of Neuropsychiatric Cases, Demobilization, and Returned Soldiers’ Insurance. See p. 394A.
10 Woods, Rehabilitation, p. 9. In 1943, Walter Woods became Chairman of the Committee following the death of McDonald.
11 W. R. Feasby, Official History of the Canadian Medical Services, 1939-1945: Organization and Campaigns, Vol. 1 (Ottawa: Edmond Cloutier, Queen’s Printer, 1953), p. vi. In March 1943, 25% of Canada’s active work force of physicians was reported to be in the armed services (J. A. MacFarlane, Medical Education in Canada [Ottawa: Royal Commission on Health Services, 1965], p. 184).
12 England, Discharged, p. 161-78. Also see National Archives of Canada (hereinafter NA), Records of Department of Veterans Affairs (hereinafter DVA), RG 38, Vol. 197 (File Special Casualties), T. D. Bain to Colonel Kinsman, 28 April 1943. Bain, Director of Medical Services for DPNH describes development of Medical Services, including development of special centres for neurosurgery, plastic surgery, orthopaedics, prosthetics, tuberculosis, and mental conditions. He notes that outside of departmental hospitals in London and Montreal, hospitalization for mental conditions would be provided through provincial hospitals, although “at the present time the Department is developing mental colonies for housing and treatment” (p. 2).
18 NA, Mackenzie Papers, Vol. 49, File 508-45(A). There are many letters of complaint and newspaper clippings about conditions at Christie Street Hospital, for example, “It Could Be Your Son,” Globe and Mail, 7 August 1944; J. Robinson, “Soldiers’ Hospital: Telling the Doctor,” Globe and Mail, 3 August 1943; and “Christie Street Hospital,” The Canadian Veteran, 3 July 1943.
20 NA, Mackenzie Papers, Vol. 49, File 519-39(3), Ross Millar to Mackenzie, 15 March 1943. Millar reported there were 18,700 beds in Canada under the Navy, Army, and Air Hospitals, 7,600 beds in DPNH hospitals, and 111,000 civilian beds.
21 NA, Mackenzie Papers, Vol. 49, File 508-45(A), J. L. Ralston to Mackenzie, 17 July 1944. Ralston noted that Colonel Currie, Director General of Medical Services, and “other officers from his branch have talked with your officers about the matter. . . . it may be, not only a matter of providing necessary DPNH accommodation, but there might be difficulties as well in . . . providing medical and nursing staffs.” Among Currie’s staff was Dr. W. P. Warner, Deputy Director General Medical Services.
24 Woods, Rehabilitation, p. 458; emphasis added.


31 Woods, Rehabilitation, p. 329.


37 Woods, Rehabilitation, p. 47-48. Overall staff levels in the Department of Veterans Affairs grew from 7,364 in 1945 to 21,038 in 1947 and declined to 14,141 in 1951. Because of the Veterans' preference in employment, 96.86% of male employees and 15.94% of female employees in the Department had seen active service in the armed forces.


39 Woods, Rehabilitation p. 330. Both MacFarlane and Farquharson had been Warner's colleagues at the University of Toronto in the 1930s. They continued to work with Warner in the RCAMC and throughout his tenure at Veterans Affairs. No evidence has been found of major conflicts about the transfer of responsibility for recruitment of physicians away from the Civil Service Commission. By 1945, Warner's former chief, Major-General Brock Chisholm, Director General of Medical Services, was the minister of the new Department of Health and National Welfare. Chisholm probably would
have supported Warner’s initiatives at Cabinet-level discussions. In 1954, Warner was awarded the Gold Medal of the Professional Institute of Public Services of Canada, the highest award in the Civil Service.


41 Feasby, Official History of the Canadian Medical Services, 1939-1945, Vol. 1, p. 56-60.


44 Woods, Rehabilitation, p. 324. Also see NA, Mackenzie Papers, Vol. 53, File 519-39(3). The recommendations for building Sunnybrook Hospital began in 1943 in response to the public outcry over the conditions at Christie Street Hospital. A report, prepared for Mackenzie, entitled Special Committee Investigation of Military Hospital Facilities, recommended the government accept a donation of land from the City of Toronto and immediately begin to build a modern convalescent hospital (W. J. Stewart to Mackenzie, 20 October 1943; Sunnybrook Hospital, built at a cost of $10 million, provided 1,450 acute care beds and replaced the often criticized Christie Street hospital, which was turned over to the City of Toronto for civilians (England, Twenty Million World War Veterans, p. 168); Woods reported the cost of Sunnybrook was $15 million (Woods, Rehabilitation, p. 324).

45 Woods, Rehabilitation, p. 326.

46 Mary Tremblay, “The Canadian Revolution in the Management of Spinal Cord Injury,” Canadian Bulletin of Medical History, 12 (1995): 101-32. Warner was a strong supporter of the development of rehabilitation for spinal cord injury. He was a member of the Board of Directors of the Canadian Paraplegic Association (CPA), founded in 1945 by Canadian veterans, from 1946 until his death in 1955. The CPA was the first organization in the world founded and administered by individuals with spinal cord injury.


53 “Report of Annual Convention,” The Legionary, 26, 5 (1950): 26; also the anonymous author of the 1945 memo to Mackenzie had criticized Warner’s proposal to introduce medical interns and nurses in training into veterans hospitals because “it would probably arouse violent opposition from the patients. . . . It also lowers the standard of service in the hospitals which is now entirely professional both in the medical and nursing

54 J. A. MacFarlane, Medical Education in Canada (Ottawa: Royal Commission on Health Services, 1965), p. 142. In 1950, 44% of all doctors, whose applications for Fellowships had been approved or were being reviewed, had received some part of their postgraduate training in departmental hospitals (W. P. Warner, "The New Concept of D.V.A. Treatment Services," The Legionary, 26, 2 [1950]: 34). The DVA hospitals opened up intern and resident appointments to civilians in July 1948 and offered the most generous stipends in Canada, for non-veteran postgraduate residents. Stipends ranged from $1,080 per annum for a junior intern to $3,300 for a resident (completion of a minimum of three years approved postgraduate training) (Canada, Department of Veterans Affairs, "The Department of Veterans Affairs Requires Junior Internes, Senior Internes, Assistant Residents, Residents," Nova Scotia Medical Bulletin, 27 [1948]: n.p).

55 R. M. Gossline, "The Progress of the Medical Service since the Advent of War," Canadian Medical Association Journal, 45 (1941): 203. Warner and many of his former colleagues at the University of Toronto, including Graham, MacFarlane, and Farquharson had been Consultants to the RCAMC.


58 "Medical Advisory Committee," Treatment Services Bulletin, 10 (April, 1947): 45. For details of committee members see NA, Mackenzie Papers, Vol. 54, File 519-501, W. P. Warner to Mackenzie, 4 February 1947, p. 1-2. Members included Dr. J. B. Collip, McGill University and Director, Division of Medical Research, National Research Council; Dr. Edmond Dubé, Dean of Medicine, University of Montreal; Dr. Duncan Graham, Professor of Medicine at the University of Toronto; Dr. G. E. Hall, Dean of Medicine, University of Western Ontario; Dr. R. F. Farquharson, Professor of Medicine, University of Toronto and President of the Royal College of Physicians and Surgeons of Canada; Dr. W. E. Gallie, leading Canadian Professor of Surgery, University of Toronto; and Dr. Wallace Wilson, President of the Canadian Medical Association.


60 Warner, "Relationship between Government Medical Services and the Canadian Medical Profession," p. 386.

61 Warner had been involved in the early research on the production of insulin in the Faculty of Medicine at the University of Toronto in 1923. This work was never published, possibly due to tuberculosis which caused Warner to leave his studies at the university in 1924 (Michael Bliss, The Discovery of Insulin [Toronto: McClelland and Stewart, 1982], p. 182).


64 VAC, DVA Box 90, File 3-84-3, Winfield to Warner, 19 April 1950; also see VAC, DVA Box 91, Vol. 1, File 3-84-7, Burns to Chipman, 21 September 1953. Personnel were 20 part-time doctors, 15 research fellows, 5 university staff members, 35 research assistants, and 37 miscellaneous personnel.


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73 Magnuson, Ring the Night Bell, p. 336-50.
74 Research and medical education have continued their central role in Veterans Administration hospitals in the United States (J. A. Gronvall, "The Veterans Administration’s Affiliation with Academic Medicine: An Emergency Post-War Strategy Becomes a Permanent Partnership," Academic Medicine, 64 [1989]: 61-66).
75 D. Sinclair and S. Rowand, eds., Together in the Academic Health Sciences Centre: Renewing the Partnership (Ottawa: The Association of Canadian Medical Colleges/Association of Canadian Teaching Hospitals, 1994); and L. Valberg, M. Gonyea, D. Sinclair, and J. Wade, Planning the Future Academic Medical Centre (Ottawa: Canadian Medical Association, 1994).
76 Neufeld, "Good Medicine and Dr. W. P. Warner," p. 130.