

Master of Arts Thesis

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Health Care in 19th Century  
Upper Canada/Ontario;  
Adaptation of a British Model

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## Preface

After having completed relevant coursework in health care in Britain and while researching late 19th century health care in Port Arthur, I became fascinated by the surprisingly advanced level of such services in Port Arthur during the last two decades of the nineteenth century. One would expect such an isolated community to have lagged far behind southern Ontario and Britain in terms of progress in health care services. Such, however, was not the case; Port Arthur, despite its obvious handicaps of size and relative isolation, managed to keep pace astonishingly well.

Yet advances in Ontario health care services did emanate from Britain. Therefore, it seemed logical to address first the conditions which stimulated innovative changes in Britain and the adaptation of these new ideas as they spread to southern Ontario before examining their effects in a more remote community.

To fully appreciate the rapid spread of ideas and subsequent changes in services that occurred in Ontario — and specifically, in a frontier community — one must first consider the stages in the development of the various fields of health care. Health care in Britain and Ontario underwent a dramatic change during the second half of the nineteenth century: what had been during the first half of the century a rather primitive form of health care now developed into a highly scientific and well-organized service. Major

discoveries in the science of medicine; public health awareness, with improved municipal cleanliness; clean water supplies and sewage removal; understanding and control of epidemics along with improved hospital facilities and nursing care had combined to bring about this revolution.

To truly appreciate the impact of such advances and the remarkable dissemination of knowledge from Britain, to Ontario, and subsequently to Port Arthur, it is necessary to establish a frame of reference: the examination of conditions in existence during the first half of the nineteenth century which served as a catalyst to dramatic changes in health care. This thesis has consequently been divided into two parts: Part I, consisting of Chapters I and II, deals with the development of the various fields of health care in Britain and Upper Canada/Ontario during the nineteenth century. Part II, consisting of Chapters III, IV and V, examines the development of the Ontario Board of Health, public health in Port Arthur and St. Joseph's hospital.

Chapter I traces the crisis in health care in Britain brought about by the industrial revolution and its demographic changes. The sanitary reform movement was a direct response to the increase of disease in certain segments of the urban population and to the need for reform. The development of hospitals and nursing care is also outlined in Chapter I, as well as the impact of the Crimean War which served as a watershed in the improvement of medical

services in Britain. Chapter II examines the conditions in Upper Canada and the response of the colony to demographic changes and the diseases brought by immigration. It also surveys the construction of the first hospitals in Upper Canada. Major discoveries in medical science, in the second half of the century, are discussed in Chapter II to emphasize the impact they had in the colony. In addition to these changes in the medical profession, improvements in hospital facilities and nursing care are also described. Finally, Chapter II outlines the advances in public health in Ontario brought about by legislation which enabled the province of Ontario to keep pace with developments taking place in Britain.

Part II of the thesis moves on to illustrate the context in which change occurred. Chapter III deals with the specific problems of the Ontario Board of Health: apathy of the municipalities; why Ontario lagged behind Britain in the enforcement of public health legislation; what was wrong with this system, and what had to be done to improve public health. There was discussion of legislation throughout the 1880's, and progress was made by the turn of the century through public education. In Chapters IV and V, case studies of Port Arthur and its Board of Health and St. Joseph's Hospital and its Nursing School are presented to show how even a small, remote community responded quickly to advances made in southern Ontario and Britain.

Although Canadian public health reformers were in contact with the American Public Health Association, the stronger influence was with the British experience. As Heather McDougall states in her essay Enlightening the Public, "Such close ties indicated clearly the extent to which the Canadians were emulating the British approach." (p.439.) Indeed, on looking at the American public health movement during the 1880's it also indicates an indebtedness to the British experience.



Part 1

The Development Of Health Care

## Chapter I

### Britain: the sanitary reform movement, and public health. Florence Nightingale's contribution to hospital, and nursing reform.

The industrial revolution brought about an economic boom in Britain but along with the increase in wealth came a proportionate decline in health. Dr T.C. Thackrah of Leeds stated that, "[t]ake indifferently twenty well-fed husbandmen, and compare them with twenty manufacturers [industrial workers] who have equal means of support, and the superiority of the agricultural peasants in health, vigour and size will be obvious."<sup>1</sup> Between 1801 and 1841, the populations of cities more than doubled as country residents flocked to old cities and filled up new ones, in search of work. Along with the growth of cities there was a dramatic increase in the mortality-rate as housing was inadequate, and people were forced to live in overcrowded dwellings, with inadequate water and drainage systems, in the growing slum areas. This demographic shift challenged the existing theory of disease as thousands of people were now affected rather than small, isolated outbreaks of contagious diseases.

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<sup>1</sup> Asa Briggs, Victorian Cities, (Harmondsworth: Penguin Books Ltd., 1971), p.145.

Preceding the nineteenth century a theory had developed that attributed infectious diseases to miasma (emanations from the earth). Miasma was associated with swamps and places where rotting vegetation and human, or animal waste, gave rise to the smell of decay.<sup>2</sup> The relationship between filth, smell and disease was the driving force behind the sanitary reform movement which was led by Sir Edwin Chadwick, Lord Ashley (better known as Lord Shaftesbury, the title he inherited in 1851) and Doctor Thomas Southwood-Smith. Even before it was known that bacteria, viruses, protozoa and worms played an important role in the spread of infectious diseases, these men were convinced that something passed from the environment, or from the sick person, to cause disease in the healthy.<sup>3</sup> They believed that overcrowding, poor ventilation and putrid smells played a major role in the transmission of infectious diseases such as the dreaded cholera and typhoid fevers.

Chadwick's interest in sanitary reform began in the mid-1830's when he was appointed to a Royal Commission to inquire into the unsatisfactory administration of the old Poor Law.<sup>4</sup> Over the next few years the

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<sup>2</sup> C. Wilcocks, Medical Advance, Public Health and Social Evolution. (London : Pergamon Press Ltd., 1965), p.100.

<sup>3</sup> Ibid., p.108.

<sup>4</sup> Ibid., p.105.

Commission received reports on the living conditions of the poor in various industrial areas. The subsequent Blue Book, of 1842, on the Sanitary Condition of the Labouring Population of Great Britain not only dealt with the slums of East London but with the living conditions in much smaller cities. The following account of the sanitary conditions in the town of Stafford, reported by Dr. Edward Knight, gives an impression of what living conditions were like for the poor.

These parts of the town [where disease was common] are without drainage, the houses, which are private property, are built without any regard to situation or ventilation, and constructed in a manner to ensure the greatest return at the least possible outlay. The accommodation in them does not extend beyond two rooms; these are small, and, for the most part, the families work in the day-time in the same room in which they sleep, to save fuel. There is not any provision made for refuse dirt, which, as the trouble, is thrown down in front of the houses, and there left to putrefy.<sup>5</sup>

Doctor Knight went on to compare these conditions with those of the Stafford Asylum: "[i]n the lunatic Asylum, which closely adjoins the town, and averages 250 patients, great attention is paid to cleanliness, and we never have any infectious diseases."<sup>6</sup> Another report submitted by Doctor Bland, the Medical Officer

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<sup>5</sup> Wilcocks, op.cit., p. 102.

<sup>6</sup> Ibid., pp. 102, 103

of the Macclesfield Union, illustrates the connection that was made between sanitation and health.

In a part of the town called the Orchard, Watercoates, there are 34 houses without a back door, or other complete means of ventilation; the houses are chiefly small, damp and dark ... To these houses are three privies uncovered; here little pools of water, with all kinds of offal, dead animal and vegetable matter are heaped together, ... the fumes of contagion spreads periodically in the neighbourhood and produces different types of fever and disorder of the stomach and bowels. The people inhabiting these abodes are pale the unhealthy, and in one house in particular are pale, bloated and rickety.<sup>7</sup>

Even before 1852 when the Poor Law Commission published The Sanitary Condition of the Labouring Population of Great Britain, attempts had been made to gain political support for reform. Lord Shaftesbury had been a Member of Parliament since 1826 and was already interested in reform when, in 1841, Dr. Southwood-Smith conducted him through slums of East London. Shaftesbury fought for health and sanitation reforms, and became a leading figure of the Health of Towns Association, which issued various leaflets to increase public awareness on health issues.<sup>8</sup>

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<sup>7</sup> Ibid., p. 102.

<sup>8</sup> J.W. Bready, Lord Shaftesbury and Social - Industrial Progress (London: George Allen and Unwin Ltd., 1933), p. 108. Dr. Southwood Smith, along with two other doctors, had presented a report on the slums of East London to the Royal Commission.

The report of the Poor Law Commission, followed by a report submitted by commissioners who inquired into the " ... [s]tate of Large Towns and Populous Districts 1844"<sup>9</sup> were used in several attempts to convince the government of the need to pass legislation that would improve sanitary conditions. It was not until 1848, however, that Britain's first Public Health Bill was passed. This set up a Board of Health of which Shaftesbury was the head. He was fully aware of the difficulties that he would be facing. "It will involve trouble, anxiety, reproach, abuse, unpopularity. I shall become a target for private assault and the public press."<sup>10</sup> As it turned out his prediction was correct.

Shaftesbury and his associates on the Board of Health, Chadwick and Smith, worked hard accumulating and distributing information, organizing Local Boards of Health and stimulating public awareness and pride in civic welfare. However, due to a lack of scientific proof, contamination of water and food, although a concern, was ~~was~~ stressed as a mode for the transmission of disease until the outbreak of cholera on Broad Street, in 1848. This outbreak led John Snow, a London practitioner, to prove that water was, in fact, the ve-

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<sup>9</sup> Ibid., p. 109.

<sup>10</sup> Ibid., p. 109.

hicle through which cholera had infected the inhabitants of Broad Street. Similar conclusions were reached by William Budd who maintained that cholera was caused by living organisms that bred in the human intestine and spread through water or food contaminated by human feces. Budd also concluded that typhoid fever was caused and spread in much the same manner. <sup>11</sup>

Although the Board of Health had been very active during the cholera epidemics of 1849 and 1853, the Board was disbanded on July 31, 1854. This occurred partly because of Chadwick's unpopularity; partly because of professional resentment within the College of Physicians, whose lethargy the three reformers had challenged; partly due to the outraged institutions - the Guardians of the Poor Law, municipal corporations or local boards - whose vested interests or civic independence were threatened; partly due to the Englishman's ideal of personal liberty.<sup>12</sup> Municipal corporations would not accept a central Board of Health which dictated that costly improvements in sanitary conditions had to be made. Nor would the individual accept the idea of compulsion, whereby, he had to build and maintain houses to certain specifications. Even to

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<sup>11</sup> Wilcocks, op.cit., p. 199.

<sup>12</sup> Bready, op.cit., pp. 105, 106.

approach the poor tenants and demand that they clean up their premises was unthinkable at this time, even though it was this group that suffered the most with the epidemics of cholera and typhoid that plagued the cities.

The end of the first Board of Health, however, coincided with the Crimean War, and a new interest in sanitary reform. During the war the entire administration of the British army, including the care of the sick and wounded, came under much public criticism. Public awareness and concern for sanitary conditions in general were heightened by the war. Yet, change did not come about quickly because of the vested interest groups and the entrenched social attitudes. It was not until 1875 that a permanent Public Health Act was passed. This Act, accompanied by amendments which followed over the next fifteen years, covered almost every aspect of public health.<sup>13</sup> The work done by the sanitary reformers of the mid-century had not been in vain.

Another reform of the mid-nineteenth century dealt with the better regulation of the medical profession, stimulated in part by the sanitary reformers. The reformers had caused resentment within the College of Physi-

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<sup>13</sup>A. W. Blyth, Lectures on Sanitary Law (London: MacMillan Co., 1893), p.17.



cians, and the issue of who was qualified to deal with public health problems would have been hotly debated. In the 1850's, Parliament encouraged the formation of associations for all professional groups as an indirect method of raising and regulating the standards of work done by them for the community. There had been a College of Physicians in London since 1518 but, by the nineteenth century a more extensive medical association was required. The British Medical Association was, therefore, founded in 1854 and, a few years later, as a result of a parliamentary inquiry, the Medical Act of 1858 created a General Council. This Council was in charge of medical education and the registration of all practitioners throughout Britain. The Council was to keep a list of all qualified doctors, approve the granting of licenses by institutions, and bring before the Privy Council cases in which the licensing bodies were not insisting on proper qualifying examinations.<sup>14</sup> Through control of the educational standards and licensing of doctors, the public could be assured of better medical treatment.

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<sup>14</sup> Sir Llewellyn Woodward, The Age of Reform 1815 - 1870. (London: Oxford University Press, Amen House, 1962), p.619. It was not clear whether this reform was brought about as an indirect way of controlling the sanitary reformers. At this stage no doctor was "qualified" to speak-out on public health issues, and this could have been used against the sanitary reformers especially men like Chadwick and Shaftesbury who were not doctors.

During the nineteenth century, of course, there was no State financed medical care; effectively, only those who could afford medical care benefited from the improved standards of control over the medical profession.

It was the poor who suffered the most through sickness, and it was this group that could not afford medical care. Although there were hospitals in Britain conditions were so deplorable in the mid-century that anyone able to afford it was treated at home; the patients in the hospitals came from the slums. The hospital wards were usually large, bare and gloomy; beds were crammed, in rooms, fifty or sixty deep with less than two feet separating each bed. <sup>15</sup> Florence Nightingale, in her

Notes on Hospitals, wrote :

[t]he floors were made of ordinary wood which, owing to a lack of cleaning and lack of sanitary conveniences for the patient's use, had become saturated with organic matter which when washed gave off the smell of something quite other than soap and water. Walls and ceilings were of a common plaster also saturated with impurity. Heating was supplied by a single fire at the end of each ward, and in winter windows were kept closed for warmth, sometimes for months at a time...After a time the smell became "sickening", walls steamed with moisture and a minute vegetation appeared. The remedy for this was frequent lime washing and scrapping, but the

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<sup>15</sup> Cecil Woodham-Smith, Florence Nightingale 1820 - 1910 (London: Constable @ Co., Ltd., 1951), p. 57.

workmen engaged on the task frequently became ill.<sup>16</sup>

Nightingale also noted that the sick came into hospital filthy and remained so :

[t]he nurses did not as a general rule wash patients, they could never wash their feet... The beds on which the patients lay were dirty. It was common practice to put a new patient into the same sheets used by the last occupant of the bed, and mattresses were generally of flock sodden and seldom, if ever cleaned.<sup>17</sup>

The attitude of the hospital physicians did nothing to improve the deplorable conditions. Patients looked upon medical attention as a luxury since the doctors, for the most part, were not concerned with the wretches of humanity. The attitude that necessity for caring for the sick should transcend social status was not evident in the mid-nineteenth century. The upper classes heard stories about hospitals but such conditions were accepted as a necessary horror.<sup>18</sup> Also, since the rest of society was removed from the slums there was little or no contact with the poor, so there was little fear of being contaminated by the "sick poor".

The influence of the sanitary reform movement was quite evident in Nightingale's Notes on Hospitals, for it was her friend Lord Shaftesbury who sparked her in-

<sup>16</sup> Ibid., p.57.

<sup>17</sup> Ibid., pp. 57, 58.

<sup>18</sup> Ibid., p. 125.

terest in sanitary reform. In the 1840's, acting on Shaftesbury's suggestions, Nightingale had studied hospital and Royal Commission reports.<sup>19</sup> Even before her Crimean experience her interest in reform, especially with hospitals and the quality of nursing care was growing.

In 1845, however, it was considered socially unacceptable for a respectable woman to become a hospital nurse; indeed, Nightingale was likely one of the first to ever have considered doing so. She wrote that, "it was preferred that the nurses should be women who had lost their character, i.e. should have had one child."<sup>20</sup> Most nurses slept in the wards they nursed in, and it was not unknown for nurses to sleep with male patients. In a letter written on May 29, 1844, Nightingale described the sleeping accommodations provided for nurses in one of London's most famous hospitals. "The nurses ... slept in wooden cages on the landing places outside the doors of the wards, where it was impossible for the Night Nurse taking her rest in the day to sleep at all owing to the noise ..."<sup>21</sup>

The nurses had no other homes; they lived, slept and frequently cooked their meals on the wards. Super-

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<sup>19</sup> Ibid., p.61.

<sup>20</sup> Ibid., p.58.

<sup>21</sup> Ibid., p.58.

vision was almost non-existent, and many nurses were notorious drunks. In 1851, a physician of a large London hospital stated that, "[t]he nurses are all drunkards, sisters and all, and there are but two nurses whom the surgeons can trust to give the patients their medicine."<sup>22</sup> In 1854, the head nurse of a London hospital told Nightingale that, "in the course of her large experience she had never known a nurse who was not drunken and there was immoral conduct practiced in the very wards, of which she gave awful examples."<sup>23</sup>

It is not surprising that the mortality-rate in hospitals was high; sick people had a better prognosis if they remained outside the hospital. Poor care, and the lack of sanitary conditions, coupled with no sterile technique meant that disease and wound infection would pass from patient to patient.

It is also not surprising that Florence Nightingale's family was shocked by, and tried in every way to quell, her interest in nursing. Nightingale described the role of women in the upper classes of British society: "[w]omen don't consider themselves as human beings at all. There is absolutely no God, no country, no duty to them at all except family ... I have known a good

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<sup>22</sup> Ibid., p.58.

<sup>23</sup> Ibid., p.58.

deal of convents. And of course everyone has talked of the petty grinding tyrannies supposed to be exercised there. But I know nothing like the petty grinding tyranny of a good English family."<sup>24</sup> In 1852, Nightingale wrote Cassandra, a description of the life of a girl in a prosperous home, which vividly illustrates the lifestyle of upper class women.

The morning is spent sitting round a table in the drawing-room, looking at prints, doing worsted work and reading little books. Everybody reads aloud out of their own book or newspaper and every five minutes something is said ... The afternoon is passed taking a little drive. We can never pursue any object for a single two hours for we can never command any solitude; and in social and domestic life one is bound, under pain of being thought sulky to make a remark every two minutes ... When night comes ... women suffer — even physically ... the accumulation of nervous energy, which had had nothing to do during the day, make them feel ... as if they were going mad ... The vacuity and boredom of this existence is sugared over by false sentiment ... women have no passion. <sup>25</sup>

Nightingale often expressed the frustration and bitterness felt by women who were ambitious and sought a career of their own. Nightingale's description of nurses further illustrated the social attitudes that were obstacles she faced in her attempts to reform hospitals and nursing care. As it turned out, it was the fact that she was from the upper class, and socially well connec-

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<sup>24</sup> Ibid., p.93.

<sup>25</sup> Ibid., pp. 94,95.

ted, that enabled her to bring about change.

Nightingale realized that before any scheme of nursing reform was embarked upon, a training school capable of producing a supply of reliable, qualified nurses must be brought into existence.<sup>26</sup> There were no schools of nursing in the 1850's, and Nightingale, who was considered qualified to lead the nursing team in the Crimea, had only three months training at Kaiserwerth Hospital in Germany. Kaiserwerth was considered the most advanced hospital of its time, but there was no scientific nursing being taught. Nightingale wrote that "[t]he nursing there was nil, hygiene horrible ... [but] there was no neglect."<sup>27</sup> It was during the Crimean War that the deplorable conditions and treatment of patients in the military hospitals was brought to public attention.

The Crimean War, in terms of management, was really no different than previous campaigns, but there was one new feature that set it apart — for the first time newspaper correspondents followed the war.<sup>28</sup> The most influential correspondent, of the time, was William Howard Russell of The Times. In 1855, The Times had a daily print of 61,000, compared to its rivals' 3,000 -

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<sup>26</sup> Ibid., p.125.

<sup>27</sup> Ibid., p.91.

<sup>28</sup> Woodward, op.cit., pp. 264, 265.

6,000, and it circulated in ordinary, middle-class homes throughout Britain.<sup>29</sup> Russell minced no words in his criticism of the organizational blunders, and the suffering of the troops. The British public, therefore, knew more about the horrors of the Crimea than they had known about any previous war — public opinion was deeply stirred.

After arriving at the military hospital at Scutari, Nightingale improved sanitary conditions, the kitchens, food supply and the laundry; she procured linen for dressings, and improved the supply of basic clothing and hygienic materials. One soldier described his sensations when he got off the filthy transport ship, and was received by Nightingale and her nurses with clean bedding and warm food: "we felt we were in heaven."<sup>30</sup> Indeed, the legend of Florence Nightingale grew in England, partially as a result of The Times but, mainly due to the survivors of the British army who told the story of her work. Even the upper classes declared themselves "fanatico for the new Joan of Arc."<sup>31</sup>

Legends tend to exaggerate the importance of individuals, nevertheless, the legend of Florence Nightin-

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<sup>29</sup> Alice Anderson, A Liberal State of War. (New York : St. Martin's Press, 1967), p.71.

<sup>30</sup> Woodham - Smith, op.cit., p. 178.

<sup>31</sup> Ibid., p.234.



gale gave her the power and prestige that enabled her to bring about hospital reform, and supported her push to organize a training school for nurses. Further, the strict discipline, much like that of the army, enforced by training schools, coupled by the role played by nurses in future wars, slowly enhanced nursing as an acceptable occupation for respectable women.

After returning from the Crimea Nightingale became involved in hospital reform. A great deal of her work for hospitals was connected with improved methods of administration and organization, improved design and construction, and improved equipment.<sup>32</sup> She realized that steps had to be taken to educate the public, and initiated a publicity campaign. In October, 1858, Lord Shaftesbury arranged for two papers written by Nightingale, on hospital construction, to be read at a Social Science Congress. These papers were received with enthusiasm and were later expanded into a book, Notes on Hospitals, which was published in 1859. This book was so successful that a second edition had to be published in 1860, with a third following in 1863.

It was Nightingale's prestige that gave her credibility and acceptance as an author and authority. She convinced others that hospitals had appallingly high death-rates because the elementary principles of sani-

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32 Ibid., p.232.

tation were being neglected. The answer to this problem was better ventilation, a higher standard of cleanliness, better drainage and better food. Floors, walls, and bedsteads needed to be scrubbed; windows and corridors needed to be positioned in such a way so as to carry foul air away. Proper heating systems needed to be installed and a larger cubic allocation of air per patient needed to be allowed. Nightingale used her Crimean experiment as an example of the effectiveness of her suggestions.

We had in the first seven months of the Crimean Campaign, a mortality-rate of sixty per cent per annum from disease alone ... We had, during the last six months of the war, a mortality among our sick little more than among our healthy Guards at home and a mortality among our troops only two-thirds what it is among troops at home.<sup>33</sup>

Following the success of Notes on Hospitals Nightingale was asked for advice on hospital construction in England and throughout Europe.<sup>34</sup>

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33 Ibid., p.295.

34 Ibid., pp. 333,334. The plans for the Birkenhead Hospital, the Edinburgh Infirmary, the Chorlton Infirmary, the Coventry Hospital, the Leeds Infirmary, the Royal Hospital, at Putney, the Staffordshire Infirmary were submitted to her. The Government of India consulted her on the plans for a hospital in Madras. The Crown Princess of Prussia requested a personal interview at which time she submitted plans for a new hospital in Berlin. The Queen of Holland submitted plans and the King of Portugal asked her to design a hospital in Lisbon.

Nightingale's scheme for a training school for nurses initially met with resistance. The primary reason for this was that some doctors anticipated interference and clashes between medical and nursing authorities. She was very careful to outline exactly what the nurses duties were, and student nurses signed contracts stating that they would give strict obedience to physician's orders. Notwithstanding, Mrs Wardroper, the matron of St. Thomas's Hospital, London, and Doctor Whitefield, the Resident Medical Officer of the same hospital, showed courage, in the face of powerful opposition, in committing their institution to Nightingale's Training School.

The object of the Training School was to recruit two groups of nurses; those who would be "ordinary" probationers and those who would be "lady" probationers. Both groups were expected to be intelligent, good women but only the latter, who came from the upper class, could be expected to have the educational background and experience necessary to train others, and to be superintendents of new training schools. Nightingale's nurses were to take posts in hospitals in order to establish a higher standard of nursing care. The nurses had to be above suspicion, the exact opposite of the drunken promiscuous nurse of old, for, if a scandal were to ever focus upon them the opponents within the

medical profession would use it to discredit the entire programme.

In May 1860, advertisements appeared inviting applications for admission to the school. Fifteen candidates were chosen on July 9, 1860. Each student had to submit a certificate of good character before admission, and their training lasted one year. Strict discipline was enforced, and Nightingale kept in close contact with Mrs Wardroper, who became the Superintendent of the School, in order that she might supervise the programme.<sup>35</sup> Her Training School for nurses was a success, and over the next twenty years her nurses spread throughout Britain and Canada. Although Nightingale was certainly not the only person concerned with the reform of hospitals and standards of nursing care, her prestige had placed her in a remarkable position.

The first half of the nineteenth century was a period wherein the reformers of the various fields of public health and medicine met with the most resistance due to entrenched social attitudes generally, and to opposition of vested interest groups specifically. The latter half of the century was the period when reform movements met with success, culminating in the passing of appropriate legislation, and in the instituting of

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<sup>35</sup> Ibid., p.346.

appropriate reforms. The Crimean War had indeed been the watershed. It seemed that slum conditions, and the resultant epidemics, therein, had done little to move public opinion but, the War conditions had touched every strata of society. Along with the Crimean War major scientific developments in all aspects of medicine furthered the cause of improved health care in Britain.

## Chapter II

### Upper Canada : advances in public health, hospitals and nursing.

Unlike Britain, the colonial experience of Upper Canada was different in that it was not war but epidemics, often triggered by waves of immigration, that challenged the public to action on public health issues and hospitals. Whereas, the immigrants to British cities had merely moved in from the surrounding countryside. Also, the relative space, and low population density further differentiated Upper Canada from the British experience. In 1820, the total population of Upper Canada was about 100,000, and it had only a few urban communities with very small populations; the two largest being Kingston which had 2,300 citizens and York with 1,250. In 1830, the population of Kingston was 3,800 and Toronto 2,900, and in 1851, 11,585 and 30,775 respectively.<sup>1</sup> It was not only the size of these communities that differentiated the physical environment of Upper Canada from Britain but the fact that the towns were surrounded by farms not slums.

Canada being a British colony meant that the atti-

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<sup>1</sup> Jacob Spelt, Urban Development in South-Central Ontario. (Toronto : McClell, and Stewart Ltd., 1955), pp. 45, 91.

tudes towards hospitals were similar. As in Britain, seriously ill patients were treated at home whenever possible, and nursing care was provided by family, or friends, according to the physicians orders. Hospitals were viewed as charitable institutions organized to treat the "sick poor" who could not afford the services of a physician. <sup>2</sup>

After the Napoleonic Wars Britain witnessed a period of economic depression that resulted in mass emigration to Canada. Some of the immigrants were of the officer class, and brought with them the attitudes of the British upper class, but those ingrained social attitudes would never be as dominant in the colony as in the mother country. The majority of immigrants did not come from this class, and were, generally, undernourished upon departure, and this accompanied by overcrowded and unsanitary conditions on the transport ships, led to disease — the cholera plagues of the early 1830's and 1840's were brought to Canada by immigrants. <sup>3</sup> Although a Quarantine Station and hospital were established near Quebec, in 1832, diagnoses and recording techniques were

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<sup>2</sup> J.M. Gibbon, Three Centuries of Canadian Nursing (Toronto: MacMillan Co. of Canada, Ltd., 1947), pp. 71, 72.

<sup>3</sup> G. Bilson, "Canadian Doctors and the Cholera," Medicine in Canadian Society : Historical Perspectives, ed. S.E.D. Shortt (Montreal : McGill - Queens University Press, 1981), p.171.

questionable, and the state of medicine was such that the incubation period for diseases was unknown. Consequently, many infected people managed to arrive in Upper Canada while the disease was still in its incubation period. As a result, a pattern developed, whereby, various communities reacted to every epidemic as a separate crisis.

Boards of Health were instituted to organize the opening of hospitals, and the hiring of medical officers; nursing was performed by concerned, middle-class, female volunteers.<sup>4</sup> After the crisis was over, the Boards were disbanded, and the hospitals were often utilized for purposes other than the care of the sick. By the mid-nineteenth century, however, this pattern had changed somewhat with the larger hospitals becoming permanent institutions that cared for the "sick poor."

Kingston, being the point of entry for immigrants moving into Upper Canada, was particularly vulnerable to disease. The Female Benevolent Society established a House of Reception containing eighteen beds which, between 1820 and 1829, treated 513 patients, mostly from Britain. In 1832, a larger hospital was built with the assistance of a \$3,000 grant from the government. After the cholera epidemic of 1834, the hospital gradually fell into disuse and, in 1839, it was used to house

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<sup>4</sup> Gibbon, op.cit., pp. 71,72.



troops; from 1840 to 1843, the hospital was used for meetings of parliament.<sup>5</sup> A substantial rise in immigration during the 1840's, coupled with the subsequent threats of epidemics necessitated the establishment of the hospital as a permanent treatment facility.

York was the primary destination of immigrants leaving Kingston and the history of the Toronto General Hospital was similar to that of the Kingston General. In 1813, the Loyal and Patriotic Society of Upper Canada founded a military hospital at York with the intention that it would be maintained as a General Hospital after the army had no further use for it; this was the first hospital in Upper Canada. For several years after 1817 the hospital was enlarged; between 1824 and 1829, however, it was occupied by the parliament of Upper Canada. One can hardly imagine a hospital building in Britain being considered suitable as a parliament. After 1829, the hospital was used for medical treatment solely, and was equipped to accommodate one hundred patients.<sup>6</sup>

The mass immigration of Irish during the 1840's added a large Roman Catholic population to Upper Canada. In response to this situation Roman Catholic nursing orders became active in the founding of hospitals in the province: the Grey Nuns established the Hotel Dieu

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<sup>5</sup> Ibid., p.76.

<sup>6</sup> Ibid., p.77.

in Kingston in 1845, and, in the same year, accepted a call to establish a hospital at Bytown which, upon completion, was named the Grey Nuns Hospital.<sup>7</sup> This religious connection ensured a degree of respectability for nursing that was not present in pre-Nightingale Britain,

Also, in response to the increased Roman Catholic population, Monseigneur Charbonnel, the Bishop of Toronto, introduced the Sisters of St. Joseph's to Toronto in 1851. In 1852, the Sisters expanded to Hamilton initially to provide care for orphans although, by 1854, they had become involved in hospital work during the cholera epidemic which was followed by an outbreak of typhoid fever. In 1861, nursing sisters were sent from Hamilton to the Hospital of St. Joseph's which they had established at Guelph.<sup>8</sup>

In 1850, Hamilton received a grant from the government of Upper Canada to construct a general hospital and, in 1852, the Protestants in Bytowns supported the establishment of the Country Carleton General Protestant Hospital. In 1859, the Galt General Hospital was opened and, in 1865, the St. Catherine's General and Marine Hospital was opened.<sup>9</sup>

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<sup>7</sup> Ibid., p. 80.

<sup>8</sup> Ibid., p. 134.

<sup>9</sup> Ibid., pp. 133,134.

The first cases of cholera arrived in the St. Lawrence on April 28th, 1832, and were landed at Grosse Isle from the ship Constantina, from Limerick. The Grosse Isle Quarantine Station had opened in the spring of that year but there were no proper quarantine precautions. Anyone who seemed well was allowed to pass; disinfection was unknown, and all the soiled clothing of the immigrants went unwashed. Infected people therefore carried the disease with them as they made their way to Upper Canada. 10

The first boats carrying cholera victims arrived at Prescott on June 16th. The inhabitants of Prescott and Kingston were unprepared but responded immediately to the crisis. A public meeting was held at Kingston, and a Committee of Management was appointed to deal with the emergency. The committee in turn sent two letters to the Lieutenant Governor, dated June 14th and June 16th, 1832, asking for financial aid and for someone to be sent with the necessary authority to enforce rules

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10 F. Montizambert, "A Hundred Years of Sanitation in Ontario", Tenth Annual Report of the Provincial Board of Health of Ontario, 1891 (Toronto : Warwick and Sons, 1892), p.5. Montizambert was the Medical Superintendent of the Quarantine Station at Grosse Isle. The Constantina carried 170 immigrants of whom 29 had died on the voyage. On May 14th the ship Robert from Cork arrived, and had had 10 deaths on the voyage. On May 28th, the ship Elizabeth from Dublin arrived with 145 immigrants and 42 deaths.

and regulations. <sup>11</sup>

The Lieutenant Governor responded with equal haste and, on June 20th, had a circular sent to the Chairman of the Quarter Session of the several districts, with measures to deal with the emergency. The Chairman was asked to convene the magistrates of the districts involved, and with their aid form a Board of Health. The Board was to assume the authority of enforcing whatever arrangements were necessary to control the epidemic. Further, the Board was to place at the disposal of the magistrates in each district the sum of £500 to provide for hospitals, Medical Officers, and for making the arrangements for a Medical Board to be formed in each district at the request of the Board of Health. <sup>12</sup>

Through these measures the cholera epidemic was dealt with, and by October it was over. The worry was that another outbreak of cholera could occur so on February 13th, 1833, an Act was passed by the legislature of Upper Canada with regard to public health; it was entitled An Act to establish Boards of Health, and to guard against the introduction of malignant, contagious and infectious disease in this Province. The Act stated that "it shall and may be lawful for the Governor, Lieu-

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<sup>11</sup> Ibid., p.6. These letters were found in the Journals of the Legislative Assembly of 1833.

<sup>12</sup> Ibid., p.7. The total amount advanced to the districts was £4,439.

tenant Governor or person administering the government, to appoint three or more persons in each and every town in the Province, ... to act as health officers within their respective limits." <sup>13</sup> It also contained among other provisions, powers stating that :

1. The Health Officers could enter in and upon premises and order them to be cleaned.
2. That the Governor in Council may make rules concerning the entry and departure of vessels, and the landing of passengers.
3. It provided a penalty of 20 shillings for the violation of any rules or regulations of the Board or obstructing officers.
4. This Act shall be and continue in force for one year, and from thence to the end of the next ensuing session of the Provincial Parliament and no longer. <sup>14</sup>

This public health Act of 1833 was met with approval. A Board of Health was formed in York, and an article in the Courier of Upper Canada dated April 17, 1833, expressed the delight at having a Board to watch over the state of public health, and to take preventive measures. The article also pointed out several nuisances in the Town that would prove fertile sources of disease. <sup>15</sup> The weakness of the Act, however, was that it was only in force for one year.

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<sup>13</sup> Ibid., p. 13.

<sup>14</sup> Ibid., pp.13,14.

<sup>15</sup> Ibid., p.7. The Board of Health for York would have demanded the cleaning up of nuisances but after the year was up the Board was disbanded and the town would revert to its former state.

The next appearance of cholera, in serious proportions, was in 1849. In October of 1848 cholera had reached England via Hamburg. For fear that the disease would spread to Canada the Central Government sent Doctors Grainger and Ayres to Hamburg to investigate the disease. As a result of their investigations an Act, providing for a Central Board of Health was passed by Parliament in April 1849. This Board of Health — situated in Montreal — notified the public of an Act passed for the removal of nuisances, and the prevention of disease. It also demanded the formation of Local Boards of Health.<sup>16</sup>

In Toronto, on June 21st, 1849, a special meeting was held for the appointment of a Board of Health. A heated discussion ensued regarding the injustice of the Act which forced municipalities to form Local Boards to do the work according to the instructions of the Central Board, and then bear the expenses. The feeling being that the Central Board should contribute to the costs. The general consensus, however, was that the system of a Federal Board was a good plan, and the Toronto Board was appointed. On June 14th the Central

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<sup>16</sup> Ibid., p.8. The Act of 1849 contained provisions that in many instances were contained in the consolidated Public Health Act of 1887, which will be discussed in Chapter 3.

Board published its regulations. <sup>17</sup>

Unfortunately, plans were made too late, and cholera broke out in Toronto on July 6th and an Iso-lation Hospital was opened on the same day. On July 25th, the Central Board required Local Boards to have houses vacated when the inhabitants neglected to clean them, or when overcrowding prevailed. By September the disease was abating but in Toronto alone there had been 745 cases and 449 deaths. <sup>18</sup>

In the autumn of 1849 cholera disappeared from the province, and did not reappear until 1854. This time the province was prepared as the epidemic never reached the proportions of 1833 and 1849. A proclamation, dated July 20, 1854, declared that the Act of 1849 was in force. Under it, the Central Board issued regulations that were very precise, and were contained in two chapters. Chapter I issued general and personal direc-

<sup>17</sup> Ibid., p.8,

<sup>18</sup> Ibid., pp. 9,10. On July 6th, in Toronto the number of cholera cases were reported as

	cases	deaths
On Scott Street, 1 resident, 4 emigrants	5	2
On King Street east, an emigrant	1	1
On March Street, an emigrant family	5	3
On Queen Street west, a carter	1	1
In Hospital, all emigrants	3	3
Emigrant shed	1	0
Totals	16	10

It is interesting to note that emigrants stayed in a shed until able to find accommodation elsewhere.

tions to families and individuals :

1. cleaning of premises.
2. keeping cellars clean and dry.
3. houses to be aired by chimney boards and stoppers removed.
4. doors to be left open day and night.
5. bedding to be aired daily.
6. personal cleanliness by tepid bath two or three times weekly.
7. flannel vests to be worn next to skin.
8. general moderation in eating and drinking, diet light and nourishing, mainly of animal food, while fish and vegetables were to be used sparingly and green vegetables ... avoided.
9. those who ... objected to the use of spiritous or fermented drinks were recommended to take tea or toast water at meals, while those accustomed to use liquors were to use them in small quantities and of the best quality.
10. long fasting and late suppers to be carefully avoided.
11. soda water as a summer drink was recommended.
12. the sick should not be attended by more persons than absolutely necessary ... lessening the danger to the public.
13. warned the public against the indiscriminate use of mineral waters and especially against the use of many kinds of patent medicines so extensively employed.
14. recommended burning, baking and boiling of clothes in 1 to 14 parts of chloride of lime.
15. advised against unnecessary alarm. <sup>19</sup>

Additional sections advised Local Boards to pay special attention to tainted meat, cellars, cesspools, privies, stagnant pools, pig-pens, slaughter houses, butcher stalls, hides and tanneries. No patient under treatment or at an Isolation Hospital was to be permitted in a church or within city limits; crowding of

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<sup>19</sup>Ibid., p.11.



graveyards was forbidden; undertakers, hotels, and boarding-houses were strictly regulated and all burials were to be private and within 24 hours. All ship captains had to report deaths on board and Local Boards were requested to report weekly.<sup>20</sup>

The influence of the sanitary reformers in Britain was evident in the stress on good ventilation and cleanliness of property and person. Cholera is spread through the ingestion of water contaminated with feces and vomitus of patients; to a lesser extent the feces of carriers or through food contaminated by water, hands or flies. Its spread from person to person by direct contact is of relatively minor importance.<sup>21</sup> Care was taken against possible sources of contaminated water; mineral waters; many kinds of patent medicines; use of only good quality liquors; drink tea (boiled water). Care was taken in the recommendations of what to eat when really, in the case of green vegetables, it was the handling of food that was the problem; hand washing, and proper cleaning of vegetables would have been sufficient. The role of flies in the transmission of cholera was not likely appreciated but the sections dealing with the inspection of pig-pens, slaughter

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<sup>20</sup> Ibid., p. 11.

<sup>21</sup> Abram Benenson, Control of Communicable Diseases in Man (Washington D.C. : The American Public Health Association, 1970), p. 53.

The following most interesting history of the importation of contagious diseases into Canada by way of the St. Lawrence has been supplied through the kindness of Dr. F. Montizambert, the Superintendent of the Dominion Quarantine Service of the St. Lawrence :

QUARANTINE STATION, GROUSE ISLAND.

Hospital Returns for the Sixty years 1832-1891.

Year.	Number inspected Port of Quebec.	ADMISSIONS.							DEATHS.								
		Total.	Cholera.	Fever.	Smallpox.	Scarlet fever.	Measles.	Dysentery and Diarrhea.	Other diseases.	Cholera.	Fever.	Smallpox.	Scarlet fever.	Measles.	Dysentery and Diarrhea.	Other diseases.	Total.
1832	51766	(No Hospital records for this year are discoverable.)															
1833	21732	239		169	34												
1834	30436	844	290	404	12		29	27									27
1835	12527	120		28	47			12									4
1836	27724	462		334	48		4	41									10
1837	21902	594		481	104			9									61
1838	3256	61		24	17			6									57
1839	7439	189		150	1			22									6
1840	22234	561		485	60			7									9
1841	3008	290		184	32		4	6									44
1842	44374	488		341	77		2	51									43
1843	21727	246		174	26			35									54
1844	20142	388		322	11		13	37									19
1845	24475	463		363	73			28									18
1846	32353	822		679	108			33									30
1847	36106	8091		6339	62			14									67
1848	27009	681		502	31		18	154									127
1849	38494	859	3	606	34		1	42									160
1850	32292	359		224	34			5									34
1851	41076	691		179	87		1	116									64
1852	39176	297		64	47		9	58									18
1853	36799	278		49	31			36									32
1854	53180	690	14	39	133		6	164									63
1855	21274	232		107	106			19									35
1856	22430	263		33	8		9	61									20
1857	32917	417		62	4		30	115									37
1858	12910	227		17	3		6	76									21
1859	8778	92		20	2			50									
1860	10150	92		16	2			49									10
1861	19923	311		14	103			66									26
1862	22176	367		151	47			37									68
1863	19419	44		17	1			26									1
1864	19147	50		31	4			20									9
1865	21455	31		5	6			21									3
1866	29618	271		23	15			67									11
1867	30757	375		31	65			42									4
1868	31400	424		10	19		2	144									28
1869	41111	494		139	60		10	68									66
1870	44475	392		1	50			175									44
1871	37050	267		10	31		27	35									7
1872	34743	339		38	77		8	45									20
1873	39801	114		4	15			3									4
1874	23994	62		2				3									3
1875	16038	70		2				1									3
1876	10900	1			1												
1877	7743																
1878	10226	7		1				6									
1879	17251	7		6				1									
1880	24997																
1881	30236																
1882	44650																
1883	45988	1		1													
1884	31529	2			2												
1885	17005	6			6												7
1886	22783	13		2	6			6									3
1887	32749	76		9			3	25									4
1888	37731	61		6	1		1	13									3
1889	2571	35		3	1			16									3
1890	27447	61		2	6		1	10									1
1891	33021	66		3	3		1	16									1

Appendix 1

houses and butcherstalls would have reduced the chance of the spread of disease through contaminated meat.

Although specific knowledge of cholera was lacking, restricting the number of people attending the patient, restricted the number of people coming into contact with contaminated feces and vomit. There were regulations dealing with stagnant water and privies but there was no mention of the care of water supplies. This epidemic of 1854 was practically the last outbreak of cholera in Ontario, primarily due to such precautionary measures.

On studying Appendix I, the statistics from the Quarantine Station at Grosse Isle, it is remarkable that cholera, after 1834, although the word was enough to cause a scare in Upper Canada, fell off sharply; "fever" was far more prevalent. "Fever" referred to typhus primarily but also to enteric fever, which was a synonym for typhoid fever. It could have been expected that typhoid fever would have been more prevalent since it is spread like cholera. The fact that there were few cholera cases registered at the Quarantine Station meant that a lot of infected people passed the Quarantine before the disease broke out, assuming the various diseases were diagnosed properly, which might have been the case. In 1849, there were 1,854 deaths as far west as Sault Ste. Marie, and reportedly a few in 1866,

apparently not detected at Grosse Isle. However, there might also have been other factors involved.

Before 1833, the province of Upper Canada was free of cholera, after 1834, if immigrants were involved what groups were being referred to? The report from Toronto on July 6, 1849, (see footnote 17) stated that there were 16 reported cases of cholera but only 1 case was from the immigrant shed; of the 3 cases in hospital there was no mention of where they were from. The rest of the cases, although registered as immigrants, were all living in Toronto, and could have been for some time. The population of Toronto, although small compared to urban centres in Britain, had grown quite rapidly. Cholera was usually confined to the lowest socio-economic group, and housing was inadequate in Toronto which led to overcrowding, sewage and nuisance problems; conditions, wherein, disease flourishes. If indeed cholera was introduced from outside the province it surely had a fertile environment in which to spread.

Although cholera was not the only contagious disease introduced to the province during the period, it stimulated the most fear and subsequent action, in terms of public health legislation. Also, the hospitals, founded as a result of epidemics were, if not the only hospitals, at least the major medical institutions

established in the pre-Confederation period. As in Britain, the hospitals of Upper Canada in the mid-nineteenth century had terrible reputations for being places of death, and this fear was only enhanced considering their original function as isolation centres. Fear was also exacerbated by the fact that doctors did not understand cholera, and the treatment they exacted was often brutal. <sup>22</sup>

The medical profession was unscientific in its approach, and the treatments for most diseases were aimed at relieving symptoms without any understanding of the causes, or the transmission of, the diseases. It must be noted that most Canadian doctors had been educated in either London or Edinburgh, and many did keep abreast of the latest innovations in Britain.<sup>23</sup> Indeed, in Upper Canada at this time the medical profession was in an unusually advanced state, there existing, from 1815, a Medical Board with the authority to examine new-comers into the province, and grant licenses to practice. In 1832, the only persons entitled to practice without examination were physicians educated at the Royal College of Surgeons of London;

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<sup>22</sup> G. Bilson, A Darkened House : Cholera in Nineteenth Century Canada (Toronto : University of Toronto Press, 1980), p.128. The favoured treatment for cholera included excessive bleeding, opium therapy and counter-irritant therapy which involved cauterization and blistering.

<sup>23</sup> Ibid., p. 174.

much to the consternation of licensed physicians from Dublin, Apothecaries Hall London and from Edinburgh University.<sup>24</sup> In 1843, a faculty of medicine was established at the University of Toronto, but was abolished by the legislature in 1852 as it was felt that the public should not finance the education of men entering such a lucrative profession.<sup>25</sup>

The Sanitary Reformers of Upper Canada were well informed about what the sanitary reform movement was doing in Britain; they realized that nuisances caused diseases even if they did not know how they were transmitted. Unlike Britain, however, there was little opposition to legislation because diseases like cholera were a very real threat to the whole community not just the poor. Police Acts were passed which gave the police the power to regulate for street improvements, nuisance control and fire prevention.<sup>26</sup>

The germ theory of the transmission of disease was generally accepted by the late 1860's, but the debate over contagion had led the public to view the medical profession as being in a state of confusion. Many laymen believed that doctors were no better equipped to

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<sup>24</sup> Montizabert, op.cit., pp. 2,3.

<sup>25</sup> Bilson, op.cit., p. 122.

<sup>26</sup> Careless, op.cit., p.73.

comment on cholera than they were.<sup>27</sup> Furthermore, since there was a lack of definitive treatment for most diseases, the trend was to seek help from men practicing homeopathic medicine; the most influential of whom was Samuel Thomson.

Thomson was an American who had established Thomsonian Medical Societies in many cities throughout the United States. In the 1850's Thomson became known in Upper Canada. Since his treatments were far less brutal, and no less effective than those of regular doctors, Thomsonian practitioners were greeted with great success in Upper Canada, and were given the right to practice by Parliament.<sup>28</sup> One important point that can not be overlooked is that scientific ideas, respect for experts and the influence of an upper class were less significant in Upper Canada than in Britain; the upper class was not as firmly entrenched or as opinionated. Since there was a high degree of illiteracy, the distrust of doctors could be related to frontier notions, rejecting "book-learning", and resisting the authority of the educated minority.

As in Britain, however, there were factors other

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<sup>27</sup> Bilson, op.cit., p. 132. Although typhoid fever was also attributed to immigration, cholera was a far more frequent peril.

<sup>28</sup> C.M. Godfrey, Medicine for Ontario : A History (Belleville : Mika Publishing Co., 1979), p. 22.

than cholera which contributed to the poor reputation of both doctors and hospitals — poor surgical techniques, the unsavory environment of hospitals and poor nursing care. Surgery, in keeping with current knowledge, was confined primarily, to amputations and tumor removal; alcohol being used as the anesthetic.<sup>29</sup> There was no understanding of the cause of infection nor how it was spread; therefore, post-surgical infections were commonplace due to a lack of sterile technique. Cross-infection from patient to patient was also common as a result of the improper care of infected wounds and equipment. Infection, accompanied by a lack of effective anesthesia, meant that surgery was extremely brutal — a nightmare that one might not recover from.

...[I]t was with the greatest difficulty [that] patients could be induced to go into hospital. It was the popular belief that, if they went in, they would never come out alive. No records were kept ... the patients had to look after themselves; fresh air was not thought necessary. Armies of rats [scavenged] about the wards. Instruments were looked after by a man who assisted in the operating room and at post mortems at the dead-house. Nothing was known of sepsis or antisepsis. Surgeons operated with dirty instruments and septic hands and wore coats which had been for years baptized with the blood of victims. <sup>30</sup>

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<sup>29</sup> Ibid., p. 22.

<sup>30</sup> G.H. Agnew, Canadian Hospitals, 1920 to 1970, A Dramatic Half Century (Toronto : University of Toronto Press), p. 3.



Admission to hospital was also resisted because of the social stigma attached to hospitalization. Since medicine was unscientific and there was a dearth of definitive medical procedures for most complaints, treatment in hospital took on a moralistic tone; it was believed that physical illness and poverty were related to moral failings.<sup>31</sup> In addition nurses in Upper Canada were untrained and often indifferent to the needs of their patients and, although not considered as degenerate as British nurses, were not respected. As in Britain, nursing as a vocation was frowned upon by cultured women, and even more by their families.<sup>32</sup> Finally, the fact that General Hospitals were funded partially by middle-class charity meant that they represented middle-class values : values which further stigmatized the lower-class users.

A pattern of hospital organization and funding began during the pre-Confederation period and continued into the twentieth century. Catholic Hospitals were run by the various nursing orders and financed through government grants and donations made by parishioners. General Hospitals were founded

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<sup>31</sup> S.E.O. Shortt, "The Canadian Hospital in the Nineteenth Century : A Historiographical Lament", Journal of Canadian Studies, vol. 18, no.4. (Peterborough : Trent University Press, 1984), p.5.

<sup>32</sup> Agnew, op.cit., p. 3. In his first chapter Agnew reviewed this early period of Canadian hospital history,

by voluntary groups which formed non-profit hospital corporations. Members of the Board of Governors of General Hospitals included wealthy philanthropists and other influential community leaders interested in charitable work. The prime function of the boards was to raise funds for the establishment, expansion and maintenance of the respective institutions. If the local municipal government, or provincial government, had given grants to a hospital, the government would appoint a representative to the Board of Governors.<sup>33</sup> Like the Catholic Hospitals, donations were also received. The Government of Ontario did build hospitals for the mentally ill as well as Isolation Hospitals, during the post-Confederation period, but the pattern for Catholic and General Hospitals continued.

The mid-nineteenth century was a bleak period in the history of hospitals, and the medical professions both in Britain and Canada. After 1860, however, the situation changed. In Ontario alone 96 hospitals were built between 1880 and 1914, 16 of them Roman Catholic; 6 were run by the Sisters of St. Joseph's; 4 by the Grey Nuns; 4 by the Sisters of Providence, and 2 by the St. Joseph's Hospitaliers.<sup>34</sup> Also, during this period there was a movement towards hospital specialization :

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<sup>33</sup> Ibid., p.2.

<sup>34</sup> Gibbon, op.cit., pp. 176, 179.

of the 96 hospitals built, 9 were sanatoriums for the treatment of tuberculosis; 5 were provincially run hospitals for the mentally ill; 4 were for the treatment of incurables, and 4 were women's hospitals.<sup>35</sup> In effect, General Hospitals began to be viewed as being less dangerous as specific diseases became isolated, and removed from that environment.

The pattern of hospital building in response to epidemics, however, continued into the 1890's. For example, 12 hospitals were built in Toronto alone in response to a series of epidemics.<sup>36</sup> After the epidemic passed people realized the need for the continued use of hospitals for short-term medical help; not only for the poor, and as shelter for immigrants as there were other factors which increased the need for hospitals. Along with an increase in population, as the result of immigration, Ontario was beginning to industrialize. With the ensuing urbanization, although not to the extent of the industrial cities of Britain, came urban congestion and the creation of the population segment particularly prone to disease — the urban poor. The middle-class realized that the outbreak of disease among the urban poor would eventually affect the

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<sup>35</sup> Ibid., p. 179.

<sup>36</sup> Ibid., p. 179.

wealthier segments of the population. <sup>37</sup> Hence, the continuing need for hospitals. Furthermore, with industrialization and the railway boom of the mid-century, followed by the building of the transcontinental railway, there was an increase in the number of accident victims requiring hospitalization. <sup>38</sup>

At the same time as the need for hospitals was increasing the medical profession was becoming more scientific and, therefore, more credible, although reliant on British research. Between 1873 and 1900, developments in medical science, and in medical practice were revolutionary. Knowledge rapidly advanced in bacteriology, physiology, pathology, chemistry and pharmacology. In the field of bacteriology most of the important bacteria were discovered, tested, grown in artificial media and proven to be the causes of the diseases from which they had been isolated. The bacteria identified included those that caused cholera, typhoid fever, tetanus, diphtheria, dysentery, scarlet fever, pneumonia and many others. <sup>39</sup> Once the causative agents were iden-

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<sup>37</sup> Bilson, "Canadian Doctors and the Cholera", op.cit., p. 131.

<sup>38</sup> Gibbon, op.cit., p. 181.

<sup>39</sup> C. Wilcocks, Medical Advance, Public Health and Social Evolution. (London : Pergamon Press, Ltd., 1965) p. 125.

tified, vaccines were developed for some of the diseases mentioned.

In the field of pathology physicians were now able to link symptoms with structural pathology more accurately and, therefore, became more precise in their diagnoses, and more rational in their treatment of disease. Aids to diagnosis were precise observation of symptoms, chemical laboratory tests and pathological studies of diseased organs and tissues.<sup>40</sup>

In the surgical treatment of accidents and disease there was the greatest impact. In 1865, as the science of bacteriology advanced, Joseph Lister developed the antiseptic surgical system, whereby, operating rooms were sprayed with germicidal solutions to reduce the risk of wound infection during surgery.<sup>41</sup> Steam sterilizers were introduced into hospitals in the late 1880's which made aseptic operative procedures possible. Also, anaesthetics were invented which meant that surgery was painless, and since it could be performed slower great strides were made in surgical procedures. Post - operative care of surgical wounds improved as did sanitary conditions in hospitals.

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<sup>40</sup> Richard H. Shryock, Developments of Modern Medicine. (New York : Alfred A. Knopf, 1947), pp. 306 - 313.

<sup>41</sup> Wilcocks, op.cit., pp. 115, 117.

As a result of this science orientated medical profession, in Ontario as well as in Britain, medical and surgical practice became increasingly specialized according to diseases, body organs and systems. To meet the demands of specialists and their services, special hospitals for the treatment of specific diseases, and research orientated hospitals connected to universities and medical schools came into being. Consequently, these hospitals required specialized services and equipment including highly trained, versatile nurses, and separate clinical areas. Here specialists could consult each other, increase their own skills and teach medical students, and other physicians the new practices of the specialities.<sup>42</sup> A non-medical factor in specialization was the development of big and middle sized cities with sufficient patients to allow specialization.

Hospitals, however, were not run solely by the Boards of Governors and their doctors; nurses helped to shape the internal character of hospitals as well. The work of Florence Nightingale did much to influence the improvements made in hospitals in post-Confederation Ontario; in terms of structure, ventilation, diet, sani-

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<sup>42</sup> Erwin H. Ackerknecht, A Short History of Medicine (New York : The Ronald Press, 1955), pp. 133, 161. This author points out that the invention of instruments, particularly the scopes, provided further incentive for specialization. The clinical thermometer and hypodermic needles had also been invented.

tation and the like. Further, Nightingale's Training School for nurses was well established by the time Ontario was experiencing its rapid growth in hospitals.

The need for well trained nurses to staff Ontario hospitals was crucial and, in response to this need, the first Training School was established, in 1874, in affiliation with St. Catharine's General and Marine Hospital. Doctor Theophilus Mack, who was responsible of the founding of the school, brought two Nightingale nurses from Britain to organize the training programme. Standards were set, and from that time on a number of nursing schools, associated with General Hospitals, were established; between 1883 and 1895, fourteen such schools were founded. Training schools associated with Roman Catholic Hospitals came later; between 1892 and 1913, thirteen schools were opened.<sup>43</sup>

Each prospective nurse was expected to show certain qualities before her admission to a Training School. As a person she should be gentle, kind, self-denying, cheerful, good-tempered and intelligent. All schools expected good health in their candidates, and most places preferred young women between the ages of 25 and 35 years; nursing was thought to be too strenuous for

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<sup>43</sup> Gibbon, op.cit., pp. 157, 158.

younger women.<sup>44</sup> Ontario Training Schools had accepted Florence Nightingale's argument that trainees live in residences. This was considered an important aspect of their moral training. The ideal was that residences should be pleasant, comfortable places where nursing students could be "mothered" by the nurse in charge as well as instructed and disciplined.<sup>45</sup> To help finance the residence, as a general policy, after six months of training nurses were sent, on request, to families requiring their care. Payment for the nurses services was given to the residence.<sup>46</sup>

The actual training received followed Nightingale's idea that nurses training should be by apprenticeship, that it could not be learned from any book. Morally and technically the nurse had to be trained. Just as the nurse's moral life and discipline had to be trained in a well-ordered residence, so the art of nursing the sick had to be learned in the workshop of the nurse,

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<sup>44</sup> Margaret Allemang, Nursing Education in the United States and Canada 1873 - 1950 : Leading Figures, Forces, Views on Education. University of Washington, 1974. Thesis, p.18.

<sup>45</sup> Isabel Hampton ed., "Sick Nursing and Health Nursing", by Florence Nightingale, Nursing the Sick, 1883 (New York : McGraw Hill Book Co., 1944), pp.33,34.

<sup>46</sup> Anne Hutchinson, "Fifty Years Ago", The Canadian Nurse, November, 1952. p. 38.



the wards of the hospital.<sup>47</sup> To gain the knowledge necessary for intelligently observing and reporting on patients to physicians, and for executing doctors orders responsibly, again following Nightingale's ideas, physicians lectured and taught students on the wards. In addition, the nurse in charge of the residence held classes, and exams. Head nurses on the wards were expected to train nurses by instruction and supervision. Other staff nurses and senior students were also expected to aid in a student's training. Students were evaluated by the Head Nurses, and the Superintendent in charge of instruction in the residence, along with examinations in course subjects, (the doctor's lectures). Students also wrote case studies on special patients which further aided in evaluation.<sup>48</sup>

Initially, physicians were expected to lecture on subjects such as chemistry, sanitary science, physiology, anatomy and hygiene, and the Superintendent of

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<sup>47</sup> Hampton, op.cit., pp. 24, 28.

<sup>48</sup> Lucy Seymer, Florence Nightingale's Nurses. (London : Pitman Medical Publishing Co., Ltd., 1960), pp. 39 - 43, 66 - 79. This guide for the teaching and training methods used at the St. Thomas's Training School in London was used by Ontario Training Schools up until 1969.

nurses held nursing classes and demonstrations.<sup>49</sup> However, in the 1890's and 1900's, course areas were expanded, at Training Schools throughout Ontario, to meet the needs of a more scientific, specialized medical profession. In 1891, physicians were giving lectures in anatomy, surgery, diseases of the lungs, eye, ear, nose and throat problems, obstetrics and gynaecology, dermatology, medicine, and contagious diseases. The nurses also received demonstrations in bandaging, surgical appliances, and urinalysis, along with other nursing procedures.<sup>50</sup> With nursing education developing along with medicine, the nurse gained status. This increased status could be seen by the number of women applying for admission to Training Schools. In 1891, the Toronto General Hospital Training School received 600 applicants; 67 were accepted on probation and 38 proved satisfactory, and were admitted to the school.<sup>51</sup> During their probationary period the prospective pupils spent four hours on the wards, helping where needed, and attended classes.<sup>52</sup> Their personalities, intelligence,

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<sup>49</sup> First Annual Report of the St. Catharines Training School for Nurses in Connection with the General and Marine Hospital, July 1, 1875, printed in History of Mack Training School for Nurses, Seventy-fifth Anniversary, 1874 - 1949, 1949. p. 13.

<sup>50</sup> Cosbie, op.cit., p. 109.

<sup>51</sup> Ibid., p. 109.

<sup>52</sup> Allemang, op.cit., p. 18,19.

skill, and general suitability were assessed at the end of this three month period.

The Nightingale system of training nurses, adopted by Ontario hospitals, did much to improve the quality of care received in hospitals and the status of nurses. As a result of the advances made, by the 1900's hospitals were able to offer the wealthy, those of moderate means, and the "sick poor" the hope of cure in a clean, pleasant and safe environment. From charitable enterprises dominated by middle-class values, hospitals had become institutions geared to efficient, scientific techniques. Many people were convinced that the techniques practiced within the hospital setting offered a quality of diagnosis and treatment unavailable elsewhere. This can be seen by the fact that during the last two decades of the century more people who paid for their hospitalization were being admitted to hospital. Indeed, by 1903, about half the revenue of hospitals came from this source. Also, in many of the newer hospitals, rooms were made available for private patients who paid extra for their own room, and as early as 1886, the demand for private accommodations often exceeded the space available.<sup>53</sup> Hospitals were no longer geared solely to the treatment of the "sick poor". In fact, in 1903, the Provincial Government Inspector

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<sup>53</sup> Shortt, op.cit., pp. 4 - 9.

of Hospitals complained that some hospitals did not pay enough attention to the poor patients, that private patients and pay patients received better treatment.<sup>54</sup>

In spite of all the positive developments that occurred in hospitals it must be noted that not everyone was willing to go to hospital when ill. Many of the Graduate Nurses from the Training Schools went into private-duty nursing in the homes of those who could afford to pay for such services. This remained a common practice well into the twentieth century; indeed, in the 1980's there are still special agencies that provide private-duty nursing services either in the home or in a private room in hospital.

The colony had borrowed and adapted ideas from Britain, and like Britain, Ontario had experienced revolutionary changes in public health, hospitals and nursing care. Nonetheless, popular zeal for health measures such as clean towns, better housing and personal hygiene soon faded after an epidemic scare had passed.

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<sup>54</sup>Sessional Papers. Second Session of the Tenth Legislature of the Province of Ontario, "Annual Report of the Inspector of Prisons and Public Charities upon Hospitals, 1903". Vol. xxxvi. - Part ix.1 (Toronto:L.K. (Toronto : L.K. Cameron, 1904), p. 7.

Part 11

The Context Of Change

### Chapter III

#### The Ontario Board of Health.

In terms of public health legislation, the province of Upper Canada had passed laws to protect public health in emergencies. However, the idea that a high standard of health required permanent care took a long time to be fully appreciated. After 1873, diseases of all varieties decreased substantially at the Quarantine Station, primarily because of improved conditions on the transport ships, and the improved physical condition of the immigrants. The fact that cholera was no longer a major threat did not mean that other diseases did not prevail. Ontario was plagued by outbreaks of smallpox, diphtheria, typhoid fever and tuberculosis. As a result, further legislation was passed after Confederation. The Municipal Institution Act of Ontario instituted important measures for preventing nuisances, the sale of tainted food, for regulating public water supplies, drainage and the disposal of sewage. Further, a Public Health Act was passed, in 1873, which contained other measures for sanitary purposes, and established the authority to carry them out.<sup>1</sup>

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<sup>1</sup> Sessional Papers. Fourth Session of the Fourth Legislature of the Province of Ontario, 1882-83,  
"Local Health Organization, Their Powers and Duties."  
Vol. XV. -Part IV. (Toronto: C.B. Robinson, p. xlix.

Section 2 of the Act of 1873 read as follows. "The members of the Municipal Council of any township, city, town, and incorporated village, shall be Health officers within their respective municipalities, ... but any such Council, may be law delegate the power of its members as Health Officers to a committee of their own member, or to such persons ... as the Council thinks best".<sup>2</sup> There was provision for the formation of active local health committees, and the Municipal Act enabled councils to pass very stringent health By - laws. It was intended that public health work of a very comprehensive nature should be initiated and efficiently carried out.<sup>3</sup> At first glance it appeared that Ontario kept pace with Britain in public health legislation; however, the fact that in most instances this legislation was not carried into effect was evidence of neglect, and reflected a poor attitude towards the necessity of permanent public health measures.

It was not until 1882 that the Government of Ontario established its own permanent Board of Health which functioned independent of Dominion legislation.

It was the recognition of the principle that the State may, and ought to, exercise a paternal care over the health and lives of the people, not in any fitful or accidental manner, as during epidemics of dis-

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<sup>2</sup> Ibid., p. xlix

<sup>3</sup> Ibid., p. xlix

eases, but in a daily supervision of the habits and manner of living of individuals and communities, in everything that tends to affect favourably or unfavorably the material well-being of the people ..."<sup>4</sup>

The Public Health Act of 1882 provided the Provincial Board of Health with the same powers as the Central Board of Health had had, and was fashioned after the British and American systems of public health.<sup>5</sup>

One of the first things the Provincial Board did was to send out a circular to the Clerk of every municipality requesting him to inform the Secretary of Board whether his Council had organized a Local Board of Health, and if it had enacted health By-laws under the Act of 1873. The results were shocking. Of the 650 municipalities only 40 answered, and of this 40 only 33 had active boards. The circular was sent out again in 1883 this time, of the 650 municipalities, 208 answered, and of the 208 only 22 had active boards.<sup>6</sup> In effect, less than one-third of the municipalities even bothered to respond. The members of the Provincial Board of Health were critical of municipal organizing where "ma-

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<sup>4</sup> Sessional Papers. Fourth Session of the Fourth Legislature of the Province of Ontario, 1882-83, "Report of the Provincial Board of Health". Vol. XV., Part IV. (Toronto: C.B. Robinson, 1983) p. lvil.

<sup>5</sup> Ibid., p. lli.

<sup>6</sup> Ibid., p. 316.



terial well-being, intellectual well-being, and spiritual well-being, are all taken in hand; but physical well-being, that on which all the rest directly or indirectly depend, has been left to shift for itself."<sup>7</sup>

The Provincial Board then set out to find out what was wrong, and what could be done to stimulate interest in, and improve upon public health. The Provincial Board established that Ontario was behind England in terms of activity with regards to public health.

England has some 1500 Local Boards of Health ... and these have succeeded, in spite of the over-crowding, wretchedness, and poverty, in reducing the annual death-rate to twenty in the 1,000. Ontario has a Health Act providing for the organization of similar boards in each of her 650 municipalities; but the words "may establish", of the Act, are too significant of the apathy which exists ... since returns for last year give most unsatisfactory results ...<sup>8</sup>

Indeed, the Provincial Board maintained that the major cities of Ontario, Toronto, Hamilton, London and Kingston, had mortality-rates close to that of London, England.<sup>9</sup>

The Board felt that by giving the Municipal Councils the choice of whether to form permanent boards of health was the primary reason why so few had active boards. Strong central control, and the idea of com-

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<sup>7</sup> Ibid., p. 316.

<sup>8</sup> Ibid., p. 388.

<sup>9</sup> Ibid., p. 321.

pulsion had been deemed unacceptable. Indeed, with the establishment of the Provincial Board its primary function was that of an advisory body with no real power to enforce legislation. The Board was to take "cognizance" of the interests of health; they were to study vital statistics, and make intelligent use of the data on deaths and sickness; they were to make sanitary investigations into the causes of disease, especially epidemics; they were to establish the causes of mortality and the effects of localities, employments, conditions, habits on the health of the people; they were to make suggestions for the prevention of infectious disease and when required advise officers of the government and Local Boards of Health on problems associated with drainage, water, disposal of sewage, heating and ventilation of any public building.<sup>10</sup>

The members of the Provincial Board analysed each of these duties, and studied their weaknesses.<sup>11</sup> With regard to statistics it was found that they were not as accurate as they might have been owing to the fact that the public had not become educated as to their importance so recording was not complete or exact enough. With regard to the investigations of the causes of dis-

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<sup>10</sup> Ibid., p. lvii.

<sup>11</sup> Ibid., p. lvii.

ease the weakness stemmed from the fact that success hinged on whether local authorities and medical men took the role of the Provincial Board seriously enough to report and record diseases properly.<sup>12</sup>

With regard to the clause that the Provincial Board would investigate the causes of mortality, it was found that there were "no means at the command of the Board which would enable it to efficiently perform such work."<sup>13</sup> As far as making suggestions for the prevention of infectious diseases the Board did much in terms of spreading information through pamphlets, however, there was no means through which such information could be put into effective operation. Again, as far as its advisory role was concerned the weakness lay in the fact that there were no arrangements, whereby, this work could be systematically carried into effect. Further, although the secretary of the Board was empowered to use every means to induce Municipal Councils to appoint Local Boards it was obvious from the results of the circular that his efforts met with little success. The Provincial Board was well aware of the limitations of

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<sup>12</sup> Ibid., pp. 198-200. The Provincial Board gave a list of suggested By-laws for the establishing of Local Boards of Health, complete with penalties, to give local authorities the power to accomplish the desired results.

<sup>13</sup> Ibid., p. lviii.

its power, and attempted to convince the legislature that some degree of compulsion was necessary.<sup>14</sup>

The Board maintained that many lives, and a great deal of money could have been saved annually but the Ontario Legislature was hesitant to enforce public health laws for political reasons.<sup>15</sup> "... the Legislature being but the representative of the will of the people, could not run too far in advance, and that the people at large must become educated in regard to these matters, and become convinced of the necessity of sanitary reform and of sanitary organization."<sup>16</sup> Ontario did lag behind Britain because of lack of awareness. The sanitary reform movement in Britain had started fighting for permanent health care legislation about forty years earlier, and in the interim the British public had been educated. The Ontario Provincial Board of Health analysed, in detail, the problems they faced in convincing the public that sanitary reforms were necessary. Again, such problems had been faced by the sanitary reformers in Britain many years earlier.

The problems the Board faced were formidable, and

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<sup>14</sup> Ibid., p. lviii.

<sup>15</sup> Ibid., p. iv. The Board calculated that 2,807 lives and \$4,000,000 could be saved annually.

<sup>16</sup> Ibid., p. v.

could be grouped under four main headings : apathy and indifference; individual rights opposed to State control; political and commercial concerns; attitudes toward the medical profession, and attitudes of the medical profession. In its reports the Board cited many instances of apathy with regard to public health. One study compiled by the Board dealt with the County of Middlesex, one of the largest and wealthiest in Ontario. In Middlesex there were good houses, good barns, good roads, and \$130,791 was spent on public schools alone; however, " ... there has not been a single instance of an organized attempt to improve the original, crude sanitary arrangements inherited from Britain of half a century ago."<sup>17</sup> Such instances of neglect were blamed on the widespread lack of knowledge as to the cause and transmission of infectious diseases.

Communities responded quickly to outbreaks of infectious diseases that excited feelings of horror. Cholera had been virtually eradicated, and it was claimed that, by 1883 smallpox had no permanent existence in Ontario.<sup>18</sup> Likewise, typhoid fever was controlled by isolation of the first cases of the disease, and the use of disinf-

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<sup>17</sup> Ibid., p. 321.

<sup>18</sup> Ibid., p. XIX. In Canada, the total deaths from smallpox, in a population of nearly two million, did not reach a dozen.

ectants to properly clean premises after the disease had abated. However, after the outbreak was under control, and the scare had subsided little attention was paid to permanent precautionary measures such as good sewage and water systems. The Ontario Board met with the most resistance over other contagious diseases such as diphtheria, scarlatina and whooping cough, among others.

In the first place, communicable diseases like diphtheria did not appear as loathsome as, say, smallpox. Secondly, their outward manifestations did not impress people with the idea that they were as serious. Thirdly, many people did not realize that most communicable diseases could be prevented, and resisted the advice of experts. The Provincial Board knew that little could be accomplished until the Municipal Councils, and the general public were convinced of the importance of permanent public health care.<sup>19</sup>

The second problem was ideological in nature but, because it was mentioned several times in the 1882-83 report, was considered an important obstacle to enforcing public health legislation — that was, the preservation of individual liberty.

The " ... compulsory removal of nuisances, public or private, compulsory vaccination,

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<sup>19</sup> Ibid., p. XIX.

compulsory removal to Isolation Hospitals, where perfect isolation can not be accomplished at home, compulsory hygienic architecture, etc., etc., seriously interfere with the "I" and mine, and the general common will is too frequently made subordinate to the individual will, and thus early stamping of infectious disease frustrated." 20

Through simple arguments it was hoped that reasonable people could be convinced that

"... no man has the natural or acquired right to expose his neighbours to deadly contagious disease by concealing it in his own house. Personal liberty to give smallpox to somebody else had better be abridged as soon as possible. Personal liberty to send scarlet fever into a school with your child is rather diabolical than beneficent. Personal liberty to infect a church with a diphtheria corpse is tempting providence to start an epidemic." 21

The job of the Board was to convince the public that with regard to health "... private liberty had to be made subordinate to the welfare of the public at large".<sup>22</sup>

Thirdly, it was not politically wise to pass laws that forced communities to comply with strict public health laws before public opinion was ready to accept such controls. Further, it was understandable that even if a Municipal Council wanted to, it would not be politically wise to allocate money for health purposes until the community at large could see the need for

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<sup>20</sup> Ibid., p. 359.

<sup>21</sup> Ibid., p. 338.

<sup>22</sup> Ibid., p. 369.

such expenditures.<sup>23</sup> However, an even greater problem lay in the fact that disease often went unreported to protect the commercial interests of the community. The concern being that if a town or city was considered unhealthy people might not want to settle or do business there. Further, various unsanitary conditions were not reported for the same reason, with the excuse that "there is nothing specially bad in the health conditions of the place in question ..."<sup>24</sup>

Along with commercial interests, civic pride was also an obstacle to the work of the Provincial Board.

It is truly surprising how jealous some places are of their reputation for healthfulness, while they will yet refuse to expend time or money for the preservation of what they so much prize. A town will allow Typhoid Fever or other diseases to be prevalent in it for months without appearing impressed by the fact; yet if a report, by any chance, reaches the outside press, indignant protestations of innocence are immediately published and emphatic denials at once issued. In this there is of course a worthy motive, viz, that of supporting the credit of the town or city, even as one would that of his country.<sup>25</sup>

The rivalry between communities could be fierce as seen at Port Arthur and Fort William in northwestern Ontario. The Board was frustrated by the fact that such

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<sup>23</sup> Ibid., p. 319.

<sup>24</sup> Ibid., p. xxvii.

<sup>25</sup> Ibid., p. xxvi.



communities valued their reputations for being healthy places, sought to protect their commercial interests from the detrimental effects caused by the fear of disease, yet did little to prevent the outbreak of communicable diseases.

The last problem faced by the Provincial Board was the matter of who was qualified to deal with public health issues. This, in turn, brought to light the attitudes towards the medical profession, and the attitudes of the physicians. The Board recognized the fact that there should be a trained sanitarian on the Municipal Councils; "... appointed to advise as to the proper sanitary conditions and regulations and to see to their being carried out and maintained."<sup>26</sup> It was found that Municipal Councils dealt imperfectly with, or totally neglected, sanitary questions primarily because the politicians knew very little, or nothing, about public health. Consequently, community problems considered more important were dealt with before any attention was focused on health issues.

The competency of medical men, who had never studied or ever really considered public health, to judge problems associated with the matter came under scrutiny. The possession of general medical qualifications did not

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<sup>26</sup> Ibid., p. 279

make a physician a sanitarian. It was argued that:

... while giving physicians their due credit, it may justly be doubted if they can ever be the chief, much less the sole agents, in this work of sanitary education and reform. Some of their number are ... little interested in matters regarding public health ... Many of the most talented are worn out with professional duties, and all of them from the very exigencies of the case have to restrict their work, chiefly to the treating of the sick, and leave the work of instruction and warning the masses to other hands.<sup>27</sup>

Moreover, public confidence in medical men was far from high. In some quarters they were viewed as being more interested in making money than helping people.<sup>28</sup> Also, it was said that doctors "... have been only too anxious to take care of us, and, indeed, we have a shrewd suspicion that, were there not so many of them, we might be better off."<sup>29</sup> One doctor went as far as to say "... in the field of preventative medicine, how shall we acquit ourselves to the responsibility, whether we shall be regarded as parasites living on the people, or the friends and benefactors of the race."<sup>30</sup>

The general consensus was that because municipal councils were not qualified, and too busy to deal with public health, Boards of Health in every community were

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<sup>27</sup> Ibid., p. 287.

<sup>28</sup> Ibid., p. 317.

<sup>29</sup> Ibid., p. 317.

<sup>30</sup> Ibid., p. 323.

an absolute necessity. It was also agreed that although medical men could not be the sole agents of sanitary reform, it was desirable that every board should be largely composed of physicians who had public health qualifications. If it was not possible to find qualified doctors, the very nature of their formal education made interested physicians the best sanitarians.<sup>31</sup> A qualified active Board of Health in every municipality was the only way to achieve improvements in public health.

Deeply aware of the need for the education of Ontario citizens on public health issues, the Provincial Board of Health turned to the press, and interested individuals for assistance. The Board was confident that it would have the support of the local press in its efforts to educate the public. "The frequency of paragraphs and editorial comments bearing upon sanitary subjects is of itself an indication that this interest of the press in sanitary science appears to be growing ..."<sup>32</sup> The Board also recognized the importance of the influence of the clergy, and urged them to use this influence toward the advancement of public health, since thereby they will powerfully advance the moral and religious good of the people."<sup>33</sup> The idea that clean-

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<sup>31</sup> Ibid., p. 287.

<sup>32</sup> Ibid., p. 298.

<sup>33</sup> Ibid., p. 284.

liness is next to Godliness" would surely have had an impact upon the average person.

Public awareness was also increased through a number of sanitary periodicals, started in the United States and Canada, that had met with limited success by 1882-83. Such periodicals were aimed at professional men and community leaders. However, it was the tradesmen who read sanitary periodicals more often.<sup>34</sup> By 1882, the Board claimed this sanitary press had "... accomplished the conversion of a large class of tradesmen from ordinary plumbers into sanitary plumbers; it has created a new profession — that of sanitary engineering; it has induced architects to change their work from a merely artistic to a sanitary character."<sup>35</sup>

The board sought to build upon the bases for public education that it already found in the province in 1882. Newspaper articles were considered one of the best ways to reach the average citizen. Sanitary conventions, held in different communities throughout the province, were also deemed effective in the dissemination of knowledge. It was decided that the pamphlets circulated after conventions must be geared to the

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<sup>34</sup> Ibid., p. 304. The terms "sanitary press" and "sanitary periodicals" were in common useage at the time.

<sup>35</sup> Ibid., p. 305.

reader:<sup>36</sup> the average person had to be able to understand what he was reading. Furthermore, circulars on epidemic prevention had to be clear.<sup>37</sup>

The Board's first pamphlet, and one that was much in demand, was titled, On the Disposal of Sewage. It contained many practical hints for the individual householder, as well as for health officials.<sup>38</sup> Another much needed pamphlet was prepared for guiding municipal councils in the formation of Local Boards of Health. It gave direction regarding the organization of such boards and the appointment of Medical Health Officers and Sanitary Inspectors. It also contained By-laws and regulations for the prevention of unsanitary conditions, and for aiding the board and its officers in performing their duties. Several copies were sent to every council, and one to every medical man in the province whose address could be obtained.<sup>39</sup>

Another pamphlet circulated, in 1882-83, illustrated how to construct a portable Isolation Hospital. Such a hospital could be erected in a matter of hours should an outbreak of any contagious disease appear in mun-

<sup>36</sup> Ibid., pp. 304 - 305.

<sup>37</sup> Ibid., pp. 287 - 288

<sup>38</sup> Ibid., p. xxxii.

<sup>39</sup> Ibid., p. xxxii.

icipality.<sup>40</sup> Further, a Weekly Health Bulletin would continue to be sent to every newspaper in the province.

Besides conventions one of the most efficient and valuable methods of imparting sanitary information were public lectures; a number of which had already been delivered at the request of Associations, Institutes, Municipal Officers and School Boards.<sup>41</sup> Indeed, teaching hygiene at schools was considered one of the most important ways to educate the public. Also, teachers were considered important in the control of infectious diseases by sending sick students home and reporting all cases of infectious diseases to the Local Health Officer.<sup>42</sup> Co-operation was the key factor in public health reform. First, people had to be convinced that most contagious diseases could be prevented; that it was to the benefit of the individual, as well as, the community to co-operate with the Local Board of Health; that co-operation between the Local Board and the Provincial Board was vital.

The problem continued to be the scarcity of active Local Boards of Health. The pamphlet on By-laws Sug-

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<sup>40</sup> Ibid., p. xxxiii.

<sup>41</sup> Ibid., p. xxxiii.

<sup>42</sup> Ibid., pp. 331, 370.

gested for the Guidance of Municipal Councils in Establishing Local Boards of Health having been circulated in July 1883, "... the Provincial Board felt after two years experience, that if its operation were to be of that practical value which the interests of public health demanded, legislation, based upon some principle of compulsion, was urgently required."<sup>43</sup> After much discussion both in, and out of the Legislature, a comprehensive Public Health Act was passed in 1884. Under this law the formation of Local Boards of Health became compulsory on the part of Councils, or on their failing to do so, on the part of the Provincial Board of Health.<sup>44</sup>

Also, in 1885, the existence of cholera at Toulon and Marseilles, in France, and fears of its appearance in Canada, led the Provincial Board to seek an amendment of the Act to have certain defects removed. This amendment gave the Provincial Board the power to require Local Boards to appoint Medical Health Officers within five days after request in cases where there was reason to fear the advent of a contagious disease.<sup>45</sup> This

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<sup>43</sup> Publications of the Government of Ontario, 1867-1900, "Ten Years of Public Health Work in Ontario". (Toronto: Warwick + Sons, 1893), p. 21

<sup>44</sup> Ibid., p. 21.

<sup>45</sup> Ibid., p. 22.

amendment was quite timely in view of the fact that an epidemic was spreading into Ontario. During the early part of the year several cases of smallpox had been reported; a few in Hungerford and other eastern localities. The organisation of Local Boards was urged in view of these facts but, especially on account of the frequency of smallpox cases in Montreal; the fear always being that infected people would make their way westward before symptoms appeared. As a result of these outbreaks, the Provincial Board sent out a vaccination circular on May 16th.

In this circular the Provincial Board requested that the Council of each municipality appoint a Medical Health Officer who was to be prepared to vaccinate.<sup>46</sup> In June a second circular was sent out in which the Board used its power of compulsion. "Should the Council not have already complied with the provisions of Section 12, Public Health Act 1884, they will ... in order to thus avoid the disagreeable duty imposed upon this Board of carrying out the provisions of Section 19 of the Act."<sup>47</sup> As a result of this legal pressure many municipalities responded. Of the 650 municipalities there

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<sup>46</sup> Ibid., p. 22.

<sup>47</sup> Ibid., p. 22.



were now 563 Local Boards, 283 Medical Health Officers and 160 Sanitary Inspectors, along with numerous Vaccination Officers. Also, Medical Officers of the Provincial Board inspected all trains and steamboats coming into Ontario from the east.<sup>48</sup>

The effect of this organization was that only 19 deaths from smallpox occurred in Ontario during the time of the Montreal epidemic.<sup>49</sup> This experience of 1885 indicated the need for further additions to the Act which "... was amended by provisions for the compulsory occupation of unoccupied premises for temporary use as isolation hospitals."<sup>50</sup> In addition, the Vaccination Act was also amended in 1886 whereby Local Boards of Health could insist on compulsory vaccination if after a month's notice the municipal councils had not reacted. Further, this amendment provided for compulsory vaccination of people every seven years in case the existence of smallpox in any municipality made it necessary in the opinion of the Provincial or Local Board of Health. Councils could also require children to present certificates of vaccination before they would be admitted to school.<sup>51</sup>

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48 Ibid., p. 22.

49 Ibid., p. 23.

50 Ibid., p. 23.

51 Ibid., p. 23.

of municipalities being practically complete in the matter of organisation.<sup>53</sup> It was hoped that with the experiences of 1885, Local Boards would come to realise that true sanitation extended to the prevention of those diseases which were of a more domestic or endemic character. During the year 1886 diphtheria caused more deaths than smallpox had at any time. In the five preceding years diphtheria had caused 4,793 deaths, while in 1886 alone there were 1,470 recorded deaths.<sup>54</sup>

As a result of this high death-rate, Regulations re: Diphtheria were drafted in 1887, and the Health Act was amended so as to give the Provincial Board power to require Local Boards to exercise "any of said powers which in the opinion of the Provincial Board, the urgency of the case demands."<sup>55</sup>

Indeed, in 1887, the Health Act was consolidated after further amendments. Legislation was improved by enactments intended to control the spread of diphtheria in the schools. Teachers were required to report all cases to the Local Board, and children were to be prevented from returning to school until they and their homes

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53 Ibid., p. 23.

54 Ibid., p. 23.

55 Ibid., p. 23.

were certified as free from contagion by the Medical Health Officer.<sup>56</sup> The regulation of ice supplies was provided for, while inspection of slaughterhouses, dairies, cheese-factories and creameries was legislated upon. The Provincial Board also drew up a series of regulations by which Local Boards could license dairy-men and milk vendors, and suggested a common standard for the quality of milk. The matter of the disposal of town refuse was also dealt with in 1887, and drawings of furnaces were supplied. A Factory Act was passed to deal with the health of employees; prevention of accidents, improvement of ventilation, and sanitary precautions.<sup>57</sup>

The Public Health Act of 1884, followed by amendments leading to the Consolidated Health Act of 1887, were the basis of public health legislation. In future years the Act was further amended to deal with specific health problems. The primary weakness in the system, however, was the reliance on voluntary adherence, as politicians feared the use of compulsion. Co-operation was sought through increased knowledge, the feeling being that strict enforcement of the law, on the continual

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<sup>56</sup> Ibid., p. 23.

<sup>57</sup> Ibid., p. 24.

basis, would only lead to cover-ups. In fact, it was argued that it would do more to harm the advance of public health."... we must combat superstition, diffuse rational knowledge, and protect the people against pestilence by the simplest and most effective means at our command, winning confidence by patient, kindly instruction, only using repression and the lash of the law when we must." 58

This attitude, of using the law only when necessary, prevailed well into the twentieth century. After the Public Health Act was passed, in 1884, the Provincial Board "urged forward" the organisation of Local Boards, in view of the threat of smallpox. Further, in the first circular the Provincial Board sent out it "requested" that within five days each municipal council appoint a Medical Health Officer to vaccinate. In the second circular the Board threatened legal action but there was not full compliance, in that there were only 563 Local Boards, 283 Medical Health Officers and 160 Sanitary Inspectors. Even by 1886 the list of Local Boards was only "practically complete", which meant that the Provincial Board never exercised its legal right to force compliance.

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58 *Sessional Papers, 1882-83., op.cit., p. 339*

The Public Health Act set in place the legal responsibility of Local Boards of Health, and gave them the power to enforce the legislation; however, it was left up to the judgement of Local Boards when to enforce. The regulations drawn up by the Provincial Board were done so "... with a view to aiding Local Boards ..."<sup>59</sup> When the Provincial Board exercised its authority, forcing Local Boards to comply to given regulations, it was done so by Order-in-Council and lasted for one year.<sup>60</sup> Likewise, Local Boards of Health were reluctant to use the full force of the Law except when the community was threatened by an epidemic.

During the 1880's advances were made in terms of organization and legislation but the idea that public health was a never ending responsibility of Local Boards, and the individual was a long educational process. In 1901, the Provincial Board of Health assessed its twenty years of progress, and was happy to report that "during the past twenty years there has been, on the whole, a very remarkable change in the habits of

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<sup>59</sup> "Ten years of Public Health work", op.cit., p.24.

<sup>60</sup> Sessional Papers. Third Session of the Seventh Legislature of the Province of Ontario, "Regulations of the Provincial Board of Health, approved by order of his honor the Lieutenant-Governor in Council, Dated 11th day of April 1893". Vol. XXV.-Part VII. (Toronto : Warwick + Sons Ltd., 1893), p.1. The regulations applied to the year 1893 only.

## Chapter IV

### A Case Study of Port Arthur. The Local Board of Health.

Municipal response to recommendations of the Provincial Board of Health varied from one community to the next; indeed, even when compulsion was used reactions had often been slow. What was remarkable was the response of a small, new community in a remote area of Ontario — Prince Arthur's Landing (after, 1884, Port Arthur).

The history of the Landing began in the 1860's as a result of Simon Dawson's work in establishing a land and water route from Lake Superior to Red River. Dawson situated the base of his operation at the Landing, on the shores of Lake Superior, where the supply stores for the development of this route were located. This activity attracted the first businesses. Then in 1868, silver was discovered on the property of the Montreal Mining Company at Silver Islet, close to the Landing. By 1869, mining operations had commenced not only at the Silver Islet mine but at the Shuniah or Duncan and Beck mines which generated considerable interest in the area. <sup>1</sup> In addition, the phenomenal success of the Silver

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<sup>1</sup> Prince Arthur's Landing, or Port Arthur, Ontario, Canada. "The Silver Gate" and her Leading Industries, ed. unknown (Winnipeg : Steen & Boyce Publishers, 1883), p.10.

Islet Mine, in its first three years of operation, excited even further interest in the mineral potential of the area.

Another factor that stimulated speculation in the Thunder Bay area was the fact that, in 1871, the Dominion Government was planning for the construction of the transcontinental railway. All the optimism generated by the potential of the mineral resources, and the prosperity that the railway would bring, was a great impetus to business speculators, and further growth of the community. As a result, by the end of 1872, hopes that Prince Arthur's Landing would expand into a major centre were high. <sup>2</sup>

By 1876, Prince Arthur's Landing acquired a few institutions which established it as the district capital — a new registry office, a court house and a jail.<sup>3</sup> The last half of the decade, however, was a period of economic depression throughout Canada but, local circumstances greatly exacerbated the situation at the Landing. The success of the Silver Islet Mine had been short lived, and "[f]rom its peak production in 1871, the mine's yield had fallen off gradually in the next four years, as the distance from the surface in -

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<sup>2</sup> Ibid., p. 11.

<sup>3</sup> Ibid., p. 23.

creased and the value of the ore diminished."<sup>4</sup> In spite of mounting deficits the mine laboured on until its final closure in 1884. Although this was the only mine in the Thunder Bay area that had been successfully worked before 1880, it had contributed to the mining craze in the district. "The number of patents issued bears some relationship to the fortunes of the Silver Islet Mine, reaching a peak in 1874, and diminishing toward the end of the decade."<sup>5</sup>

At the same time the Landing was facing competition from the much older fur trade community at Fort William. The Dominion Government decided, in 1875, to use water-transport as far west as Fort William then begin the transcontinental railway there — " ... the people of Prince Arthur's Landing [had] received a staggering blow".<sup>6</sup> Although all the supplies for the railway came through the Landing the fear was that it would be by-passed; the danger was viewed in terms of local rivalry. The population at the Landing was larger than that of Fort William but both communities were tiny which meant that a place as small as Fort William could

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<sup>4</sup> Thunder Bay District 1821 - 1892 : A Collection of Documents, ed. Elizabeth Arthur (Toronto : University of Toronto Press, 1973), p. Ixxiv.

<sup>5</sup> Ibid., p. Ixxv.

<sup>6</sup> "The Silver Gate" and her Leading Industries, op.cit., p. Ixvi.



triumph if the government decision of 1875 stood. There was, however, a far greater danger developing in that circumstances were placing the entire project in jeopardy. The astronomical costs came under such scrutiny that the feasibility of a transcontinental railway was questioned.<sup>7</sup> During the year 1878, the problems related to the railway came to a head. British Columbia was threatening to secede from Confederation since the Dominion Government was not fulfilling its commitment to build the transcontinental railway.<sup>8</sup> The Macdonald administration committed itself but progress was slow as the poor economic conditions did not change immediately.

The problems associated with the mines, and railway meant that the Landing was in a tenuous economic position in the late 1870's. In spite of the downturn many established businesses remained solvent, and waited for conditions to change. In 1879, following the decision of the government, there was some speculation at the Landing as a few new businesses were opened.<sup>9</sup> Further-

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<sup>7</sup> Arthur, op.cit., p. Ixvi.

<sup>8</sup> W.N. Sage, "British Columbia Becomes Canadian", Readings in Canadian History : Post-Confederation, eds. R.D. Francis and D.B. Smith (Holt, Rinehart and Winston of Canada, Ltd., 1982), p. 16.

<sup>9</sup> "The Silver Gate" and her Leading Industries, op.cit., pp. 62-65.

more, the fact that business activity was more lively was a natural result of railway construction even though a small contract for 113 miles, only, had been issued.<sup>10</sup> In 1880, the Macdonald government found suitable investors, and in the spring of that year, negotiations were opened with a group of businessmen associated with an American midwestern railway. In February, 1881, an Act was passed ratifying a contract and chartering the Canadian Pacific Railway Company.<sup>11</sup>

With this contract for a complete transcontinental railway there was no longer fear of being left out. Resentment against Fort William continued, but the Landing was the acknowledged leader of the 1880's — ready for further institutional development. By the summer of 1881 there was much activity at the Landing, and real estate prices began to rise rapidly.<sup>12</sup> With the discovery of gold, the Thunder Bay area entered another period of mining enthusiasm. The Crown Lands Reports of the 1880's supported an optimistic view of the future of mining in the area. Indeed, between 1882 and 1885, a number of mines had begun operation with

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<sup>10</sup> Ibid., p. 13.

<sup>11</sup> W.T. Easterbrook and H.G. Aitken, Canadian Economics History (Toronto: The MacMillan Company of Canada Ltd., 1956), p. 426.

<sup>12</sup> Leading Industries, op.cit., p. 14.

American investors playing a major role.<sup>13</sup> Between 1882 - 1883 eight businesses that sold food products alone opened.<sup>14</sup> The Thunder Bay Lumber Company was founded, and the harbour was developed further to accommodate the increase in shipping.<sup>15</sup> Also, to accommodate the number of people — speculators, immigrants, construction workers - that passed through the community, nine hotels had been constructed by 1883.<sup>16</sup>

The business community was geared to supplying the mines and railway construction operations. All types of food stuffs flowed through the Landing as evidenced by the establishment of a considerable number of businesses involved in the sale of groceries, confectionaries and general provisions, in addition to various wholesale and retail butcheries and bakeries. There were several men's clothing and shoe stores along with other service outlets and secondary industries. The nine hotels were all equipped with bars to accommodate a large transient workforce, and the thousands of immigrants who passed through Port Arthur on their way to the west.

In 1884, Prince Arthur's Landing was incorporated

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<sup>13</sup> Arthur, op.cit., p. Ixxv.

<sup>14</sup> Leading Industries, op.cit., pp. 35, 36, 40, 44, 47, 52, 53.

<sup>15</sup> Ibid., pp. 29, 75.

<sup>16</sup> Ibid., pp. 55-59.

into the town of Port Arthur. It was a "boom town" with its leading citizens speculating in land and business ventures. There was a lot of buying and selling going on, goods and services flowing and people arriving. The town was particularly vulnerable to outbreaks of communicable diseases due to its rapid growth, and its transient population. A Board of Health was formed, in response to the Public Health Act of 1873, but it appeared to be quite ineffectual.

The issue of health care, in Prince Arthur's Landing, was discussed in The Thunder Bay Sentinel, in 1875. In a letter to the editor Dr. John Cook congratulated the paper on a previous article on the necessity of a village hospital. He went on to say that many a life had been lost because there had been no hospital. He argued that the boarding houses were not the appropriate places to house sick men because of the poor care received, and the fact that healthy men were obliged to sleep in the same room with someone perhaps suffering from a contagious disease. Dr. Cook argued further that the problem of health care was likely to give the Landing a bad name, and could deter, especially people from Britain, from settling at the Landing. Such a comment suggested that people from the "old country" were more aware of health care problems. He maintained that more than one man had said that he was leaving for fear that he would fall sick in his boarding house, and be neglected. Dr. Cook warned that such people inform.

others and exaggerate what was already bad enough. He added that with so many men employed in the mines and the railway there would be an increase in the number of accident victims with no place for adequate treatment. He also pointed out that drainage was poor, and the sources of drinking water contaminated. He reminded the public that medical authorities in Europe, Asia and America agreed that bad water was one of the chief causes of cholera, typhoid fever and other diseases.<sup>17</sup>

Another letter to the editor, written shortly after Dr. Cook's article, congratulated the paper on an article on the sanitary needs of "this isolated but central place".<sup>18</sup> This letter to the editor also argued the need for a hospital, and went as far as to give a location, a plan of the structure needed and the costs involved.<sup>19</sup>

Dr. Cook had tried to convince "the Clergy, certain influential inhabitants and the Municipal Council,"<sup>20</sup> of the need for a General Hospital, an Isolation Hospi-

<sup>17</sup> Dr. John Cook, "The hospital Question", The Thunder Bay Sentinel. vol. I, no.2 (Thursday, August 5, 1875), p. 3, col. 4.

<sup>18</sup> "Health vs. Sickness", The Thunder Bay Sentinel, vol. I, no.3 (Thursday, August 12, 1875), p.3, col.3.

<sup>19</sup> Ibid., p. 3. The name of the newspaper changed over the years of its publication, but was commonly referred to as The Sentinel.

<sup>20</sup> Cook, op.cit., p.3.

tal and sanitary reforms but they "had all agreed that the time had not come."<sup>21</sup> The resistance of governing bodies was frustrating for people directly involved with health care problems even in a small, isolated community. Although medical men were fighting for action, with the support of a local newspaper, nothing was done, in part because of the depression of the late 1870's, and in part because of the low population density. The letters to the editor of the Sentinel concerning the sanitary and institutional needs at the Landing stopped. However, the concerns of the mid - 1870's illustrated the degree of awareness — most citizens having come from southern Ontario. The arguments used had been rooted in the economic concerns of the community as appeals to the middle class citizens who had a desire to attract new settlers and investors in order to develop the landing into a thriving metropolis.<sup>22</sup> Such arguments were the basis of what was to come in the early 1880's.

In terms of public health, how responsive any community was to the requirements of the new Provincial Board of Health was likely to depend on the interest

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<sup>21</sup> Ibid., p.3.

<sup>22</sup> John L. Love, "The Founding of St. Joseph's Hospital", Thunder Bay Historical Society, vol. II. (Published by the Thunder Bay Historical Society Inc., 1974), p.4.

and concern of people in influential positions. At the Landing a group of such individuals became actively involved in the health movement in the early 1880's. They included such people as Drs. T.S.T. Smellie and John F. Clarke, C.J. Stillwell, editor of the Sentinel, Thomas Marks and his nephew George T. Marks, who held interests in merchandizing, rail contracts and the lumber industry, the Rev. Mr. Mc Morine of St. John's Anglican Church and Councillors George Clavet, W.G. Smith, who was involved with railway contracts with Marks, W.F. Davidson, who held shipping interests on the Great Lakes, and Vigars, who was involved in the lumber industry. Their actions were a result of the increased population, and the expected increase in the permanent and transient population. The major concern, in the early stages, was not for the citizenry but with the transient workers. This interest in the health of workmen seemed to result from the awareness that a reputation of poor health could deter people from coming to the area, and the fact that if hurt or sick the workers were brought to the Landing and placed upon the charity of individuals and hotels or boarding houses; an inadequate system that would soon be unable to cope. <sup>23</sup>

In January 1883, a crisis developed that was effi-

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<sup>23</sup> Ibid., p.6.

ciently handled, and reported on to the Provincial Board of Health by Drs. Clarke and Smellie. Dr. Clarke was originally from Simcoe and had practised medicine for many years in Norfolk County. He had been the Liberal M.P.P. for North Norfolk in the 1870's, and would have been familiar with the public health movement before the formation of the Provincial Board of Health. He had been a frequent visitor to the Landing where two of his sons operated a drug store. In 1879 he was appointed the first Sheriff of the Thunder Bay District; an office he held until his death in 1887. Dr. Smellie, in turn, was originally from Fergus, and had graduated from the McGill Medical School in 1877. In Montreal a lot of work had been done in the public health area which would have influenced him. He set up a medical practise at Prince Arthur's Landing in 1879, and during the construction of the Canadian Pacific Railway was the Medical Superintendent of the railway for the district.

On January 4, 1883, Dr. Smellie received a letter from his assistant, Dr. McCammon, that a man had died of smallpox in a railway camp 42 miles east of the Landing. Dr. McCammon had the man buried immediately, and had placed the camp under quarantine; before his arrival at the camp, however, four or five men had left after realizing what the man had died of. Within an hour Dr. Smellie had sent a telegram to the Provincial Board



requesting a " ... supply of reliable vaccine",<sup>24</sup> which was sent at once; he also ordered, by telegraph, a supply of disinfectants from Winnipeg. The smallpox victim had come from Winnipeg and had become ill after leaving the Landing, headed for the railway camp where he was to work; it took him a week to get there and he had slept at other camps along the way. Dr. Smellie disinfected every camp that the victim had come in contact with, and forwarded disinfectants to Dr. McCammon.

Dr. Smellie had asked Dr. McCammon to secure the co-operation of the contractors to establish a system of permits, and to allow no-one to travel from one camp to another without a properly signed order permitting him to do so. No action, however, was taken as men were scarce, and the contractors were afraid to admit that a case of smallpox had occurred; some went as far as to accuse Dr. McCammon of a wrong diagnosis. However, by the 16th of January the disease had appeared in another camp, and at the Landing as well; all except one case involved were men who had fled the infected camp.

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<sup>24</sup> Sessional Papers, Fourth Session of the Fourth Legislature of the Province of Ontario, 1882-3, "Report of the Provincial Board of Health", vol.xv, partiv. (Toronto : C.B. Robinson, 1883), p.96. Dr. Smellie asked for reliable vaccine, the problem being that the quality of vaccine varied. People were often afraid to be vaccinated. In 1886 the Provincial Board decided to start a vaccine farm in Ontario, under Government and Provincial Board Inspection.

What was viewed as remarkable was that everyone who had fled from an infected camp was laid low by the disease, while a very large proportion of those who remained in quarantine never contracted smallpox; this was attributed to vaccination. New cases appeared from time to time till about the middle of February. In all, nineteen cases occurred in the railway camps, and six at the Landing; five of the six men were from the infected camps, the sixth was Dr. Smellie, who contracted a mild case of the disease. <sup>25</sup>

Dr. Clarke, acting as Sanitary Inspector, reported that after the outbreak of January 16th he, and the Chief Police Commissioner of the Canada Pacific Railway travelled to the camps to investigate the situation. Two constables were instructed to prevent all people from either leaving or approaching the infected camp and the others placed under quarantine. Boards of Health were set into operation in the municipalities of Neebing, Shuniah and Prince Arthur's Landing, and the Public Health Act of 1882, which had instituted the Provincial Board, was printed and circulated. Also circulated was a pamphlet issued by the Provincial Board giving directions for isolation and disinfection. A smallpox hospital was established three miles from the

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<sup>25</sup> Ibid., pp. 96, 97.

Landing, and infected people were moved there. <sup>26</sup>

On Monday, April 2nd quarantine was raised; however, before being released the forty men were supplied with new clothes, and were obliged to give up their old ones. Each man was inspected then required to bathe thoroughly in carbonated water under supervision. Then, because poor construction made the camps difficult to disinfect they were burnt to the ground. <sup>27</sup>

Dr. Smellie concluded his report by stating that this outbreak of smallpox had been preceded by an epidemic of chickenpox of a severe type; that the majority of cases of smallpox were very mild although in the severe cases the death-rate was high. He reiterated that the spread of smallpox was due to men who left the camp in hope of not contracting smallpox. Dr. Smellie also suggested that camp bosses should be given the authority to place their camps in quarantine pending the arrival of a competent authority, and to prevent the departure of any of their men. By this means it was hoped to prevent the spread of disease should another outbreak of a contagious disease occur in the railway camps. <sup>28</sup>

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<sup>26</sup> Ibid., p. 98.

<sup>27</sup> Ibid., pp. 97, 98.

<sup>28</sup> Ibid., p. 98.

Dr. Smellie commented on the fact that the Local Board took no precautionary measures to prevent the arrival of more infected people from the west. Nor were any steps taken to prevent such an occurrence when the rush of immigration from the east would start in the spring. The Provincial Board took this more seriously than the local authorities, and used it to put pressure on the Federal Government for better control and inspection at the Grosse Isle Station.<sup>29</sup>

The Provincial Board found the reports of both doctors most illuminating. A noteworthy fact was that the men who were detained and vaccinated escaped the most serious effects of the disease. Another fact, that seemed to reinforce the observations of other physicians, was that a severe type of chickenpox had preceded the outbreak of smallpox. Further, the Provincial Board concluded that the close relationship between chickenpox and smallpox was probably due to the fact that conditions favourable for one served for the development of the other; that the danger of smallpox becoming epidemic arose from a false diagnosis in the first place (not the case with Dr. McCannon) or from the selfish interest of those whose businesses might be unfavourably affected, and were ready to accuse the

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<sup>29</sup> Ibid., p. 280.

physician of creating unnecessary alarm; that isolation and disinfection, thoroughly enforced, were sufficient to stop the spread of the disease, if applied to the first cases; that vaccination modified the susceptibility to the disease or modified its severity; that the mortality-rate from smallpox did not seem to be less than in former times in people who had not been vaccinated. A large proportion of those first affected, and who were not vaccinated, died.<sup>30</sup>

In 1883, as a result of this incident, a re-organization process began, and Port Arthur formed its permanent Board of Health in June 1884, as the new Public Health Act required before, be it noted, most communities in southern Ontario. The response of Port Arthur to sanitary changes was remarkable in view of its isolation, its newness and its size. Not insignificant is the fact that Dr. Smellie was a member of the town council as well as the Medical Health Officer.<sup>31</sup>

The members of the Port Arthur Board of Health were appointed on June 16th, and the Public Health Act was read. The Board set to work immediately, and agreed to notify the Harbour Master to instruct the Masters of Vessels not to throw refuse onto docks or overboard

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<sup>30</sup> Ibid., p. xx.

<sup>31</sup> Minutes of the, Town of Port Arthur, Local Board of Health, June 16th 1884 to February 24th 1896 and from May 7th 1898 to December 31st, 1906., p. 11.

within a mile from shore; notices to this effect were to be printed and circulated.<sup>32</sup> The Board met six more times in 1884 and dealt with matters quite in advance of most southern communities.

On June 26th, the Board made plans for the maintenance and improvement of drainage ditches; for the removal of soil to the Nuisance Ground, then in existence, and discussed a suitable location, and construction of a new Nuisance Ground.<sup>33</sup> On July 12th, the Secretary of the Board was instructed to " ... authorize police to act, during prevalence of diphtheria in the town, as deputy sanitary inspectors."<sup>34</sup> Individuals were to be served 24 hours notice to clean up nuisances on their premises.<sup>35</sup> The Board was also concerned about having a supply of pure water and ordered the erection of suitable pipes to be located in an area that would ensure good water.<sup>36</sup> Also, at the same meeting the Board ordered the "removal of nuisance from ditches, by the Board of Works, to be deposited in the Nuisance Ground. 37

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<sup>32</sup> Ibid., pp. 1 - 3.

<sup>33</sup> Ibid., pp. 3 - 5. Nuisance meant "garbage dump" in this case but, it was a term used to describe garbage, rotting vegetation, or stagnant water.

<sup>34</sup> Ibid., p. 5.

<sup>35</sup> Ibid., p. 6.

<sup>36</sup> Ibid., p. 6.

<sup>37</sup> Ibid., p. 6.

On July 28th, 1884, the Board discussed tenders for the construction of the new Nuisance Ground and awarded the tender to the chosen contractor. They also discussed the construction of a well and sewers.<sup>38</sup> On August 11th, the Board dealt with financial matters.<sup>39</sup> On September 16th, after appointing a new Sanitary Inspector the Board made arrangements to "have all ditches cleared out in which any stagnant water is now lying."<sup>40</sup> On September 20th, the Board notified the Sanitary Inspector that any premises found in filthy condition were to be cleaned, and anyone who defaulted was to be prosecuted by the Inspector. Leaflets were printed, to be delivered to each household, notifying the public of the enforcement of Sanitary By-Laws;<sup>41</sup> the By-Laws having been circulated by the Provincial Board.

The Port Arthur Board of Health met again on January 17th, 1885, and discussed the town's ice supply. It was noted that scientific tests had proven that freezing did not destroy deleterious matter in water; therefore, the ice harvest was to be taken far enough away from the shores of Port Arthur to ensure good ice. Notices

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<sup>38</sup> Ibid., pp. 7, 8.

<sup>39</sup> Ibid., pp. 9 -10.

<sup>40</sup> Ibid., p. 11.

<sup>41</sup> Ibid., pp. 12 -14.

were to be sent to ice cutters informing them that ice could not be taken from less than 1,500 feet from shore. The By-Laws regulating water carriers, with regard to rates and proper handling, were put into effect. The Board also discussed the establishment of a thorough system of earth closets in the more populated areas. <sup>42</sup>

A special meeting was held on January 28th, in which the Board discussed one of the sources of water supply in Port Arthur. They had found that the water taken from the Bay was unfit for use. A committee was appointed to find a new source.<sup>43</sup> On February 2nd, the Board expressed concern that earth closets were becoming a growing nuisance. It was decided that a special cart, for the removal of night soil, be acquired, and privies close to water supplies were to be closed. The inspection of dairies and cows was also decided upon at this meeting;<sup>44</sup> cows, and consequently their milk, were the chief source of tuberculosis.

On February 9th, the Board recognized the fact that

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<sup>42</sup> Ibid., pp. 16 - 18.

<sup>43</sup> Ibid., p. 20.

<sup>44</sup> Ibid., pp. 23-25. Night soil was the term used for human excreta which was collected for disposal at night. Earth closets were used where there were no sewers; they were pits in the ground used to receive human excrement - toilets.



the outbreak of disease in Port Arthur was directly related to poor sanitary regulations and to the lack of a system of sewage.<sup>45</sup> The Board was partially successful in convincing the Town Council to allocate funds for a sewer system but it was not until 1905 that a complete system of sewage and water supply was established.<sup>46</sup> The Board ordered the removal of all filth and nuisance to lessen the danger of an outbreak of "the dangerous diseases or fevers that might arise from imperfect sanitary arrangements."<sup>47</sup> The public was notified to comply to the clean-up precautions. The Queen's, Lighthouse, and Pacific Hotels were ordered to be closed while their water closets were cleared out. Further, the Board ordered the inspection of slaughter houses, and inspectors to report thereon.<sup>48</sup> The Board met two more times in February but nothing of great importance was discussed.

The Board met again on March 6th and again on March 9th, at which time it was decided that they would have strict control of waste removal and that nuisance and night soil would be removed in approved containers only.<sup>49</sup>

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<sup>45</sup> Ibid., p.28.

<sup>46</sup> Ibid., pp. 459, 460.

<sup>47</sup> Ibid., p.28.

<sup>48</sup> Ibid., pp. 28-30.

<sup>49</sup> Ibid., pp. 38 - 40.

In addition, on April 9th, the Board ordered that "all parties having slops to make removal convenient for the scavenger with proper use of dry earth [and] ashes to deodorize waste".<sup>50</sup> On April 24th, the Board purchased lots for more Nuisance Grounds. Also, the business section of Port Arthur was deemed filthy, and the enforcement of sanitary conditions ordered.<sup>51</sup>

The summer of 1885 passed without incident. The Board met in July, and ordered a sample of water to be taken from one of the town wells, which would have been tested by the Provincial Board.<sup>52</sup> In September, they went over their financial statements.<sup>53</sup> In October, however, the town was threatened by smallpox. The Russian immigrants who had been allowed to pass the Grosse Isle quarantine had become ill by the time the steamers had arrived at Port Arthur. The Board ordered the Western Express Company, and its agents to have all passengers inspected by health officials before leaving the boats, and a committee was appointed to find suitable premises for a smallpox hospital.<sup>54</sup> This way the disease was

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<sup>50</sup> Ibid., p.43. The term "scavenger" meant garbage collector.

<sup>51</sup> Ibid., pp. 45-47.

<sup>52</sup> Ibid., p. 49.

<sup>53</sup> Ibid., pp. 50 - 52.

<sup>54</sup> Ibid., p. 54.

contained. This incident, again handled by Dr. Smellie, and the subsequent report thereof was used by the Provincial Board of Ontario to bring about the necessary changes at the Grosse Isle Quarantine Station.

The Board of Health in Port Arthur met three times in November, and on the 18th they discussed the outbreak of smallpox in Montreal. After the incident in October, the Board was very much aware of just how threatening the situation was; "considering the close relationship of this Town to that City ...",<sup>55</sup> mandatory vaccination was ordered and enforced at Port Arthur.<sup>56</sup>

On February 2nd, 1886, new appointments were made, and on February 11th, a committee was appointed to investigate the town's water supplies. On March 25th, the problem of nuisance came up again as some people were not burying night soil in the Nuisance Ground. Consequently, stricter rules were enforced regarding access to, and use of the Nuisance Grounds which were to be reserved for the scavenger and other appointed carriers.<sup>57</sup> The year 1886 went by without threat from any disease. The Board of Health met monthly, and dealt with specific nuisance problems.

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<sup>55</sup> Ibid., p.58.

<sup>56</sup> Ibid., p.58.

<sup>57</sup> Ibid., pp. 67 - 101.

On January 13th, 1887, the Board met to discuss test holes for new water sources for the town. New appointments were made on February 7th, and the Board met several times in March and twice in April. On May 4th, a case of diphtheria was reported, and a placard was placed on the house which stated what the disease was, and restricted entry. At the same meeting the Inspector was asked to examine, and report on all town drains, and any in need of repair done so by the Public Works Department. Also, the Board recommended that a filter be placed at one of the water supply sites pending the construction of a system of water works. On May 10th, they reviewed estimates of the costs to improve water supply conditions. 58

In 1888, the Board of Health met monthly. On March 8th, they decided that all water carriers had to be licensed by the Council. On June 7th, they ordered the thorough cleaning of all ditches by the committee of Public Works. The Board also ordered the removal of nuisances from certain residents property. Further, the Medical Health Officer, Dr. Smellie, was to confer with the School Boards regarding the desirability of having children vaccinated prior to returning to school .59

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58 Ibid., pp. 96-117.

59 Ibid., pp. 123-133.

On July 2nd, the Board met to discuss the problem of diphtheria at a boarding house. The nuisance there was to be cleaned, and if an outbreak of diphtheria should occur in the town legal action was to be taken against the owners. Towards, the end of the month the situation at the boarding house was discussed; the disease had been contained as there was no outbreak of diphtheria in the town.<sup>60</sup> The rest of the year went by unremarkably. In his report to the Provincial Board, for 1887, Dr. Smellie explained why there had been relatively few cases of really serious illness, and why the death-rate had been unusually small.

He attributed the improved state of health to several factors. Firstly, "[b]etter house accommodation, and, in particular, the absence of over-crowding, which formerly caused so much of the sickness."<sup>61</sup> The fires of the previous winter had destroyed four or five blocks of buildings in the town centre, the over-crowded section of Port Arthur. The buildings destroyed in the fire were replaced by more spacious and healthy structures with all desirable conveniences. Secondly, better attention had been paid to the condition of the

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<sup>60</sup> Ibid., pp. 136, 137. July 27th.

<sup>61</sup> T.S.T. Smellie, "Report To Port Arthur Board of Health," Ontario Sessional Papers, 1888, no.41 (Toronto: Workwick & Sons, 1888), p. 33.

streets, drains and yards.<sup>62</sup>

In early spring all householders were compelled to clean their property. An examination of all streets, cellars and drains was made by the Medical Health Officer (Smellie himself), and a report was submitted to the Board of Health on which immediate action was taken. In most cases the nuisance was cleaned by the owner. When the matter was not taken care of, by the owner of the premises, a report was sent to the Town Council which then took appropriate action. Because of this system of compulsion the issue of non-compliance with previous orders did not dominate the agenda of the Board. By late spring there was no known nuisance existing in the town. Dr. Smellie was assisted in his work by the Sanitary Inspector, who was also the Chief of Police.<sup>63</sup> The same conditions held true for 1888 as, again, there were relatively few cases of serious illness.

The year 1889 passed uneventfully. The Board of Health met on March 27th, and discussed the cleaning of the nuisance ground, and the construction of sewers on four streets.<sup>64</sup> At the same meeting they ordered "in any

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<sup>62</sup> Ibid., p.33.

<sup>63</sup> Ibid., p.33.

<sup>64</sup> Minutes of the Port Arthur Board of Health, op.cit., p.149.

case where contagious disease of any kind, such as measles, whooping cough, chickenpox etc. exists, there shall be placed a placard announcing the nature of the disease ..."<sup>65</sup> The Board also ordered that two lot owners drain the stagnant water on their property. During the meeting on April 21st, it was decided that privy vaults or cesspools must be approved by the Medical Health Officer yearly. The topic on October 11th was the drainage from houses on a street examined by Dr. Smellie; the Board ordered the water to be drained.<sup>66</sup> So ended the first six years of the Port Arthur Board of Health.

The achievement of the Port Arthur Board of Health in its first six years was an enviable one. The town had made advances at least equal to much longer established centres in southern Ontario — and much of the credit belonged to the energetic Dr. Smellie. The Board realized that permanent care was necessary to prevent disease; it was always vigilant for any possible source of disease, and had regular clean-up periods. The Medical Health Officer and the Sanitary Inspector made regular inspections of buildings and property, and where any nuisance was found they reported to the Board, which took immediate action. The members of the Board and Town

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<sup>65</sup> Ibid., pp. 149, 150.

<sup>66</sup> Ibid., pp. 151-153.

Council were not afraid to enforce the law, and did so when necessary. The fact that regular orders had to be given to ensure sanitary conditions meant that the public was slow in appreciating the relationship between filth and disease. Also, the Port Arthur Board of Health had had some success in installing at least a partial sewer system, and improving the water supply of the town.

With the beginning of the 1890's, however, the picture changed drastically. A new depression created doubts as to whether Port Arthur could survive, and Dr. Smellie took a pessimistic view. He moved to Birtle, Manitoba in 1890, and when he did return, it was to set up a practice in Fort William. Those who remained, members of the Board of Health or not, became absorbed in a fight for survival in which all the old antagonism to a prospering Fort William was re-kindled — and had little energy left for innovative action on matters of health. In fact, the slump of the 1890's witnessed a regression from the standards set earlier.

In the late 1880's, the collapse of world silver prices brought a virtual end to the mining era of the Thunder Bay District, and by the beginning of the 1890's mining operations were closing down.<sup>67</sup> The optimism of the 1880's, that Port Arthur would somehow share with

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<sup>67</sup> Arthur, op.cit., p. Ixxv.



Fort William the affluence which the C.P.R. would bring, was also shattered. The policy of the C.P.R. had made Fort William the divisional point between east and west, and the railway invested in the construction of mammoth elevators there. At Port Arthur, however, only the King's Elevator (begun in 1883 and ready for the 1884 crop) was built until a new railway — the Canadian Northern — made the town the centre of its activities in 1902.<sup>68</sup>

At Fort William the extent of elevator building, and the amount of grain shipped through the community, in contrast to what was happening at Port Arthur, was illustrative of why the inhabitants of Port Arthur felt such resentment towards their neighbours. The 1884 wheat crop from the west amounted to 1,500,000 bushels while the 1885 crop was 2,500,000 bushels. The need for elevators to store grain was urgent, and in 1885 the Canadian Pacific Railway built Elevator A in Fort William. With a capacity of 1,000,000 bushels, it was larger than King's which could hold only 250,000 bushels.<sup>69</sup> In Fort William a boom in elevator building was underway. In 1887, the west produced a bumper crop which meant that more storage facilities were needed. Subsequently, Ele-

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<sup>68</sup> Jenny Beck, "A Solute to the Thunder Bay Grain Industry on its 100th Anniversary", Port Days (Thunder Bay, August 2, 1983), p.8, col.3.

<sup>69</sup> Ibit., p.8, col. 3.

vator B was built in time for the 1889 crop; it had a capacity for 800,000 bushels of grain. Elevator C, which served as an annex for A, was built in 1890 and elevator D was built in 1897. Although there was a lapse in building during the slump of the 1890's men were still needed to work on the railway or in the elevators. During the first decade of the twentieth century many new elevators were added to the harbour front with a total value of \$8,500,000.<sup>70</sup>

In the meantime Port Arthur struggled to maintain the businesses already established there. One of its projects was a street railway connecting Port Arthur to Fort William. It was hoped that Fort William would become a suburb of Port Arthur, with people working in Fort William but living in Port Arthur. Although Port Arthur won the battle for the street railway Fort William grew, and the terms under which the railway was forced to operate came close to bankrupting Port Arthur.

Difficulties arise when trying to find an accurate account of the decline of Port Arthur, and conversely, the growth of Fort William prior to the turn of the century "... because of discrepancies in the census records themselves and variations in the categories used

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<sup>70</sup> Ibid., p.8, col. 6.

in different enumerations."<sup>71</sup> Also, the citizens of both communities assumed that a direct relationship existed between population and influence. As a result, varying estimates of the size of each community were constantly being offered and disputed. All that can be firmly established, therefore, is that the population of Fort William rose from inconsiderable numbers as late as the mid - 1880's.<sup>72</sup> Fort William was incorporated as a town in 1892, and both Port Arthur and Fort William were incorporated as cities in 1907. The population of Fort William had grown from between 3,500 and 4,000 in 1901 to 16,499 by 1911 — Port Arthur was slightly smaller.<sup>73</sup>

The fact that the Thunder Bay harbour was developed between 1885 and 1910, coupled with the close proximity of Port Arthur to Fort William, meant that Port Arthur would survive. It is difficult, however, to determine the number of businesses that went bankrupt in the late 1880's and 1890's. Because the business community was

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<sup>71</sup> E. Arthur, "Inter-Urban Rivalry in Port Arthur and Fort William, 1970/1907". Western Canada Past and Present. Ed. A.W. Rasporich (Calgary : McClelland & Stewart West Ltd., 1975), p.60.

<sup>72</sup> Ibid., p. 59.

<sup>73</sup> Fifth Census of Canada, 1911, Areas and Population by Province, Districts and Subdistricts, Vol.I. (Ottawa : C.H. Parmelee, 1912), pp. 539,540. Discrepancies appear in the 1901 census. On page 334 the population of Fort William is cited as 3,997 and on page 539 as 3,633.

so dependant on mining, and the railway it is certain that with the decline of these industries, the prosperity of Port Arthur declined proportionately.

Port Arthur was a community under economic stress, and in terms of public health was not ready for innovations, and was not as vigilant in maintaining sanitary standards. The Board of Health's three meetings in March 1890, and one in December accomplished little.<sup>74</sup> The pattern of infrequent meetings continued in 1891 when it met once in February, and twice in April. On April 7th, the Medical Health Officer and the Sanitary Inspector were ordered to inspect yards and other premises, and to demand the removal of any nuisances.<sup>75</sup>

An epidemic occurred in 1892, and although the Board responded by setting-up isolation precautions, it was too late to halt the spread of diphtheria. It appeared that the disease had been prevalent in the town in February, before the Board reacted. It met on February 8th, and ordered the cleansing of a well. On February 25, the Board discussed the health condition of the town, and ordered the Secretary to procure placards, for the various communicable diseases, according to the rules laid down in the Public Health Act and its amendments.

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<sup>74</sup> Minutes of the Port Arthur Board of Health, op.cit., pp. 155-160.

<sup>75</sup> Ibid., pp. 161-165.

It was as late as April 19th that the Board decided to rule that public and separate schools should be thoroughly cleansed; that a sewer be installed down one street, and that a refuse hole in the public school grounds be filled.<sup>76</sup>

A week later the Board ordered that "all clothing worn by children and nurses, and the bedding used by the children during their illness be destroyed",<sup>77</sup> no disinfection was ordered. It was only at the special meeting held on June 3rd, that the Board ordered that all drains be cleared and all streets be cleaned. At a series of meetings that month the Board took actions one might have expected much earlier. It decided that "it [was] necessary to build or procure a House of Isolation for the purpose of Diphtheria cases and other contagious diseases ..."<sup>78</sup> Two days later arrangements were made to set up a farm as a House of Recovery. Sanitary constables were appointed to guard houses where diphtheria cases existed but the patient was too sick to move to the Isolation Hospital. Any unauthorized persons removing the contagious disease cards were to be prosecuted. Further, the Board telegraphed the Provincial Board of Health, in Toronto requesting that a

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<sup>76</sup> Ibid., pp. 172 - 180.

<sup>77</sup> Ibid., p.180. April 26, 1892.

<sup>78</sup> Ibid., p. 185. June 10, 1892.

nurse, trained for diphtheria cases, be sent to Port Arthur.<sup>79</sup>

At another special meeting on June 24th, the Board of Health decided on tariff charges for the Isolation Hospital : \$4.00 for a child and \$5.00 for an adult per week. It ordered the disinfection of houses where diphtheria patients had been taken to the Isolation Hospital, and the arrest of anyone who did not comply with quarantine. By mid-July the epidemic of diphtheria was over, and the Board ordered that the nurses and curators at the House of Recovery be discharged as there was no further use for them.<sup>80</sup> It may well be questioned whether the Board's actions contributed very greatly to this outcome.

The tone of many of the subsequent meetings recalls the warning of the Provincial Board a decade earlier that civic pride, and rivalry with other communities could hinder progress in public health. The Port Arthur Board of Health responded defensively to any suggestions that their town was an unhealthy place to live. An article in the Ottawa Citizen of July 16th, roused their ire. They despatched a resolution to that newspaper declaring :

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<sup>79</sup> Ibid., pp. 186-188. June 12, 1892.

<sup>80</sup> Ibid., pp. 190-196. July 12, 1892.

The statements in the said paragraph are untrue:

- 1) that no time was the late outbreak of diphtheria virulent in this town.
- 2) that in no one family were there four deaths from this disease.
- 3) that there have been only 9 deaths registered since January 1, 1892 (not 50-60)
- 4) that at present there are no case or cases of diphtheria or other contagious diseases in Port Arthur. <sup>81</sup>

Through this article sent to the Citizen the Board attempted to protect the reputation of the town. Even if the Citizen had its facts wrong, the point was that the Port Arthur Board of Health had neglected its duties over the prior two year period, and had not isolated the first cases of diphtheria. Consequently, the disease had spread rapidly from February reaching epidemic proportions by June when the Isolation Hospital was opened.

The article in the Citizen had also said that the epidemic had been reported by a person from Port Arthur — not Fort William. In retort, the Board did not directly blame Fort William for the diphtheria epidemic but, it did lash-out against its rival by issuing a statement that because "contagious diseases have been carried to our town from Fort William and, whereas, it has become known that smallpox is prevalent in Victoria

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<sup>81</sup> Ibid., pp. 199, 200. July 21, 1892.

and Vancouver, B.C. ... and that the said disease is ... travelling rapidly Eastward ... ",<sup>82</sup> the following precautionary measures were to be taken.

- 1) that the Electric Street Railway Car Conductors be instructed to carry no passenger or passengers who appear to them to be ailing from any contagious disease unless such person or persons hold a certificate bearing mandate from some Medical practitioner known to them to the effect that they have no contamination ...
- 2) that the Mother Superior [of St. Joseph's Hospital] be requested to take into the Hospital no patient outside of our Corporation except such as it is necessary to admit on account of accident to them.<sup>83</sup>

It was unrealistic to expect the conductors on the street railway to be able to identify contagious diseases. Furthermore, St. Joseph's was the only hospital in the District so if an Isolation Hospital were not opened in Fort William in time to treat the first cases of disease, it would spread rapidly. What this illustrates was just how bitter the competition was between the two towns as there was no co-operation even on the control of disease.

Also, during the meeting of July 21st, in view of the prevalence of smallpox in the west, the Port Arthur Board of Health ordered that all citizens be vaccinated.<sup>84</sup>

<sup>82</sup> Ibid., p. 198. July 21, 1892.

<sup>83</sup> Ibid., pp. 198, 199. July 21, 1892.

<sup>84</sup> Ibid., p. 200.



It met again on August 4th, at which time it ordered the improvement of a sewer on one of the main streets.<sup>85</sup> However, there were no other preventative measures taken and, as with the diphtheria epidemic, the Board was unprepared for the outbreak of smallpox that occurred in September.

On September 21st and 22nd, the Board met to deal with this outbreak, and decided that school-boards were to advise parents that they must provide evidence that their child had been vaccinated within the past seven years, or do so at once. Then, realizing they did not have enough vaccine, more was ordered from the Provincial Board of Health. A solicitor was asked if the Board had the power to enforce compulsory vaccinations, and to prevent patients suffering with infectious diseases to be brought from outside the municipality to be treated at St Joseph's. The Board was unaware of its legal right to enforce compulsory vaccination, and it had been unfair to expect the Mother Superior of St. Joseph's to turn sick people away. The Board instructed the Isolation House Committee to open an Isolation Hospital, and, finally, all nuisances in town were ordered to be cleaned-up.<sup>86</sup>

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<sup>85</sup> Ibid., p. 201.

<sup>86</sup> Ibid., pp. 206 - 210.

On September 29th, the Board of Health ordered the removal of smallpox patients from the Argyle Hotel to the Isolation Hospital, and the proper disinfection of the hotel. It also ordered that all sewers be flushed out.<sup>87</sup> By late October the disease was abating, and the Port Arthur Board sent a request to the Provincial Board for financial aid due to the costs incurred throughout the year in the management of contagious diseases.<sup>88</sup>

In spite of the economic stress the town was under, the Port Arthur Board of Health lacked the dynamic leadership Dr. Smellie had provided. However, the mismanagement of the epidemics of 1892 did not go without notice. As early as the meeting of February 25th, the Board had wanted to replace the Medical Health Officer, Dr. Macdonell, on the grounds that he was not fulfilling his duties. Nonetheless, it was not until late October, that the Town Council appointed the right man for the job. Dr. J. S. Beck had been on the medical staff of St. Joseph's Hospital since the 1880's, and was also a Town Councillor at the time of his appointment.<sup>89</sup> In the years that followed Dr. Beck's appointment

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<sup>87</sup> Ibid., p. 211.

<sup>88</sup> Ibid., pp. 214, 215. October 24, 1892.

<sup>89</sup> "Medical Health Officer", The Thunder Bay Sentinel, vol. XIII, no. 48. (Friday, October 21, 1892) p.3, col. 3.

public health was maintained at Port Arthur. In 1893, the Provincial Board of Health warned of the possibility of cholera reaching Port Arthur from the east. The Port Arthur Board met and prepared for the establishment of a quarantine and Isolation Hospital.<sup>90</sup> Although the disease never reached the town, it was ready. In 1894 and 1895 there was nothing remarkable reported on public health issues.

Although the records of the Port Arthur Board of Health were not available for the years 1895 - 1898, the Provincial Board reported that at Port Arthur there was a general sanitary inspection at intervals throughout each year; that the diphtheria vaccine was in common use, and the treatment of diphtheria was "very satisfactory" (a comment not used in the treatment of the disease in other municipalities); that disinfection, after contagious diseases was being carried out under the supervision of the Medical Health Officer; that systematic inspection of schools was being carried out; also, that there was systematic removal of garbage and nightsoil.<sup>91</sup>

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<sup>90</sup> Minutes of the Port Arthur Board of Health, *op.cit.*, pp. 230 - 233.

<sup>91</sup> Sessional Papers. Third Session of the Eighth Legislature of the Province of Ontario, 1897. "Report of the Provincial Board of Health, 1896", Vol. XXIX - Part IX. (Toronto : Warwick Bros. & Rutter, 1897) pp. xxii - xxv.

Generally speaking there was an improvement in the Board of Health after 1892.

The Board of Health met three times in 1899, and in 1900 it first met on May 1st to discuss an outbreak of smallpox which, again, reached epidemic proportions. What is significant, however, is that the Board, under Dr. Beck's vigorous leadership, had acted quickly and thoroughly in its attempt to prevent the spread of the disease. On the same day as the first meeting of the Board, the house of the first person infected was placed under quarantine, with watchmen employed on a twenty four hour basis to prevent anyone entering or leaving the premises. The principals were notified that all the school children had to show proof of vaccination before attending the schools. The following day the Board telegraphed to Toronto to have a nurse sent to Port Arthur. On May 20th, the schools were closed and fumigated. All out-buildings, yards and homes were also fumigated, and parents were advised to keep their children on their premises.

By this time the Isolation Hospital was ready with Dr. Beck in charge. On May 23rd, churches were closed, and the Chief of Police was instructed to prosecute any one entering quarantined homes. Firm action, also, had to be taken on June 3rd, when the Pacific Hotel, after being quarantined, forced smallpox victims to leave.

The Hotel management refused to take the men back unless the Board paid in advance. The Board reacted strongly, and ordered the Chief of Police to open the hotel by force, if necessary, and return the quarantined guests. The infected guests returned, and were later moved to tents outside town while the Pacific Hotel was fumigated. On June 5th, hotel keepers were notified that they were to admit no person without proof of vaccination.

Further problems arose when the Board found out that "girls" had visited the Isolation Hospital. The Sanitary Inspector was to find out who the girls were, and quarantine them. On June 23rd, the quarantine was raised on churches as the disease had abated.<sup>92</sup>

The problems the Board faced during this outbreak of smallpox indicated that some people lacked awareness or did not appreciate the work the Board was doing to contain the disease. This lack of education, with regards to public health, could be attributed, in part, to the economic problems the town had been dealing with and, in the case of the men at the hotel, a transient population.

As the fortunes of Port Arthur improved with the Canadian Northern Railway link to the west, the popula-

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<sup>92</sup> Minutes of the Port Arthur Board of Health, op.cit., pp. 296 - 325.

tion grew. Along with population growth came health problems. The Board completed the building of the sewage and water systems, which were installed between 1902 and 1905, and were a step in the right direction for the permanent prevention of disease. A By-Law was passed, in 1905, which made it mandatory for all citizens to connect their houses to these systems, after which, the Board noted that the number of diphtheria cases had decreased.<sup>93</sup> Also, during this period, from 1902 to 1905, the Board was far more active in regulating the quality of milk, meat, and ice. This activity could be attributed to the interest of the community leaders; the vitality of the Board of Health and the Health Officer, or the fact that the public was becoming better educated in terms of public health.

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<sup>93</sup> Ibid., pp. 459 - 460.

## Chapter V

### St. Joseph's Hospital of Port Arthur

Public health was not the only field of health care addressed by the town of Port Arthur. In the early 1880's, while controlling the spread of infectious diseases among the railway workers, another health care need became readily apparent — the need for a hospital. St. Joseph's Hospital, which had a humble beginning in the wing of a convent, was the only hospital in the Thunder Bay District until the Victorian Order of Nurses opened a Cottage Hospital in Fort William in 1898. Like the founding of so many other hospitals throughout Ontario, St. Joseph's was founded as a result of the needs of the community.

In 1875, Dr. Cook, and other medical men, with the support of the Sentinel, had argued the need for a village hospital. Civic pride had been used in their arguments but examples had also been cited to bolster their arguments, such as the case of August Laing who was crushed by a falling tree. He had had a fractured pelvis, dislocated hip and an impacted fracture of the head of the thigh bone. August's injuries were taken care of but the question had been where he could go for convalescence. After consultation, five surgeons decided he would have to go to Toronto. At great risk August was transferred and recuperated. Two other cases

were cited : one a man with a fractured leg and one with a fractured ankle, both of whom were convalescing at boarding houses. A case of inflammation of the eyes completed this list that had been compiled over a one month period. The three men who had remained at the Landing had had to rely on the charity of individuals for their care. The hospital facility suggested at this time was to have been small with a six bed capacity.<sup>1</sup> Such suggestions were not acted upon in the 1870's but the groundwork had been laid.

With the improved economy, and the increase in the population in the early 1880's, as a result of the construction of the Canadian Pacific Railway, the need for a hospital became even more imperative. The old arguments gained credence as the same problems existed. When workmen were injured on the job, or suffered from disease, the construction camps did not have the facilities to deal with them, and since the workforce was transient the injured men could not go home to be nursed by their families under a doctor's supervision. Some benefited from the charity of individual families but others were not as fortunate.

The injured men were brought to Prince Arthur's Landing by train or handcar, and in effect, dumped.

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<sup>1</sup> "Health vs.Sickness", The Thunder Bay Sentinel, Vol.1, No.3 (Thursday, August 12, 1875) p.3, Col.3.



"Here, they found hotel rooms or were taken to private homes ... Often, they were just put in the corner of an empty building until some other arrangements could be made".<sup>2</sup> The realization that private charity was a questionable source of relief, on a large scale, prompted action from the desire of the citizens, and especially the owners of hotels, not to harbour at their expense, the indigent sick and injured of the construction gangs.<sup>3</sup>

On September 7, 1882, C.J.Stillwell, T.Marks, G.T. Marks, Rev. Mr. McMorine and Councillors Clavet, Smith, Vigars, Davidson and Dr. Smellie, the same group interested in sanitary reform, approached the local M.P. of the Algoma riding, Simon Dawson, to discuss the possibility of a hospital for the community. Their efforts were assisted by a donation of land by the Roman Catholic Church, and the services of the Sisters of St. Joseph's convent as nurses. Five nuns of this Order had arrived at the Landing in August 1881, to run a new separate school which opened in September of that year. The nuns had soon identified the need for a hospital,

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<sup>2</sup> George Campbell, The Spirit, the Lamp and the Key a chronicle of St. Joseph's Hospital Thunder Bay, during its first 100 years (published by St. Joseph's Hospital, Thunder Bay, 1984), p.33.

<sup>3</sup> John Love, "The Founding of St. Joseph's Hospital", Thunder Bay Historical Museum Society. Vol.11 1974 (Thunder Bay:Thunder Bay Historical Museum Society, Inc., 1974), pp. 6, 7.

and were willing to extend their services. Dawson assured the delegation that "there could not be the slightest doubt as to the necessity of such an institution. There would in a short time be some 2,000 men at work on the line of the C.P.R."<sup>4</sup> Dawson added that the land grant was not a suitable location. In subsequent meetings, held in 1883, there was some question over whether it would be a General Hospital or a Catholic Hospital.

The first hospital committee meeting that was held took place in the home of Thomas Marks. Those in attendance included C.J. Stillwell, G.T. Marks, T. Marks, Mrs T. Marks, Mrs Russell, Miss V. McVicar, Miss E. Donnelly, Mrs Kennedy and Mrs Smellie — the fact that middle-class women were involved was indicative of the pattern throughout the province. Father Hamel presented a proposal which donated a portion of the convent for use as a temporary hospital, rent free for five months, and the services of the Sisters. The committee, however, decided to approach the Dominion and Provincial governments, the C.P.R. and the North American Rail Contracting Company for financial aid for the establishment and maintenance of a General Hospital. They also decided that public meetings should be held to give the

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<sup>4</sup> Ibid., p.7. The Thunder Bay Sentinel, September 7, 1882.

matter the greatest attention.<sup>5</sup>

At the first public meeting a discussion took place into the major problem of the hospital scheme, that of financial support. Dr. Smellie reported that his attempts to gain financial assistance had failed. A prominent official of the C.P.R. had felt the responsibility lay with the Contracting Company, and they in turn had felt a hospital was the responsibility of the community.<sup>6</sup> Although most people ended up agreeing, the difficulties faced regarding financing seemed to take away enthusiasm. In January 1884, C.J. Stillwell commented that "the spark has been waning and now there is scarcely a flicker."<sup>7</sup> In effect, the establishment of the hospital was not the outcome of citizen action. On February 2, 1884 the Sisters of St. Joseph began to operate a temporary hospital in the new wing of their convent. Their efforts went unnoticed in the Sentinel as C.J. Stillwell was arguing for a General Hospital.<sup>8</sup> Later in the year, as the idea of a General Hospital faded, the hospital gained considerable support in the press while the permanent institution was being built.<sup>9</sup>

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5 Ibid., p. 7. Sentinel, October 17, 1883.

6 Ibid., p. 7, 8.

7 Ibid., p. 8. Sentinel, January 7, 1884.

8 Ibid., p. 9. Sentinel, February 2, 1884.

9 Ibid., p. 10.

In its first year of operation, from February 1884 to February 1885, the hospital had certainly fulfilled its function, to relieve the town of the burden of the sick or injured transient workers, as 178 patients had been treated <sup>10</sup> — regardless of religious affiliation. Therefore, the nuns had considerable public support in the financing of the hospital. They received private donations, and in June 1884, they approached the Town Council and received a building grant of \$250. On top of this the Council drew up a By-Law whereby the hospital would receive a grant of \$50 per month. Although not officially opened until 1885 the new hospital was well under way in the fall of 1884. On behalf of the Sisters the Town Clerk applied to the Ontario Government for a grant and, after inspection, the Sisters received a building grant of \$300. <sup>11</sup> The hospital consisted of a two-storey building measuring 40 feet by 46 feet. The basement contained the dining room, kitchen, laundry and sleeping quarters for the nursing sisters. The ground floor held a large ward, private wards, a reception room, bath room, dispensary and the surgery. On the second floor were two large dormitories and three private rooms. <sup>12</sup> In all the hospital could

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<sup>10</sup> Sentinel, op.cit., Friday February 20, 1885.

<sup>11</sup> Campbell, op.cit., p.40.

<sup>12</sup> Sentinel, op.cit., Friday February 20, 1885.

accommodate twenty five patients. The Inspector for the Ontario Government added "that an Order-in-Council [be] passed authorizing the St. Joseph's Hospital at Port Arthur be taken as named in Schedule A of the Charity Aid Act, and that aid under the provisions of such Act be granted to the Hospital from the 1st October, 1884."<sup>13</sup>

The Charity Aid Act had been passed in 1874, and provided that every institution named in Schedule A would receive twenty cents per day for every patient treated in hospital. An additional ten cents per patient was also granted providing the Provincial contribution did not exceed one quarter of the hospitals total revenue. In 1879, the Act was amended to limit aid for any patient to a period not exceeding 270 days. In 1895, the Act was further amended to the effect that no aid would be given for patients who paid for their hospitalization. It also reduced the period of payment for indigent patients from 270 days to 120 days. The Charity Aid Act remained in force, with only minor amendments, until 1912, when it was revised under the title The Hospitals and Charitable Institutions Act.<sup>14</sup>

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<sup>13</sup> Sessional Papers. Second Session of the Fifth Legislature of the Province of Ontario. "Report of the Inspector of Prisons and Public Charities upon Hospitals, 1884. Vol. XVII. - Part vi. (Toronto : Grip Publishing Co., 1885), p. 45.

<sup>14</sup> The Hospitals of Ontario, A Short History, compiled by the hospitals division of the Department of Health (Toronto : Herbert H. Ball, 1934), pp. 18, 19.

Besides the financial aid received from the Provincial and Municipal Governments, the hospital also received donations from private companies or citizens of both Port Arthur and Fort William. Donations also took the form of goods such as stoves, coal, food, linen and hospital furnishing.<sup>15</sup> One nun, Sister Monica, was particularly adept at raising money, and has been credited with personally collecting a large portion of the funds that financed the later expansions. During the first two months of operation, she developed a novel system that gradually evolved into a health care plan. She canvassed the construction camps on the railway, and convinced workers to pay small, regular amounts to her hospital for which they received a card that prepaid any care they might eventually need — an early form of medical insurance.<sup>16</sup>

On staff at the hospital were Doctors Beck, MacDonnell, Bryson, Smellie and Campbell (who died in 1885). The daily routine, however, was left to the nuns who, likely with no formal training, nursed patients under doctors' orders. The nuns cooked, boiled the

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<sup>15</sup> Campbell, op.cit., p. 38.

<sup>16</sup> Ibid., p. 39. No mention of this method of fund raising has been found in the histories of the Toronto General or Kingston General Hospitals. It does not mean, however, that such rudimentary health care plans did not exist elsewhere.

linen and surgical equipment, and scrubbed the wooden floors; the ladies of St. Andrew's Roman Catholic Church helped with the cleaning. In 1895, the Ladies Auxiliary was formed; an organization made up of volunteers who raised money through teas, bake sales, bazaars, bridge tournaments and other such projects. This money was contributed to the hospital's capital costs, or went towards vital supplies such as bedding and linen. The women of the auxiliary also helped with the cleaning of the hospital.<sup>17</sup>

In 1886, in his second report to the Provincial Government, the Inspector of Hospitals had a few complaints about St. Joseph's.

The bedsteads in use are of a very bad style and should be replaced by those of a proper pattern with wire mattress combined ... The closet arrangements, too, are not at all good.<sup>18</sup>

By 1889, apparently all such problems had been dealt with as the Inspector presented a glowing report. "[St. Joseph's] now ranks as first-class in every respect; there is not a neater or more comfortable

<sup>17</sup> Ibid., p. 51.

<sup>18</sup> Sessional Papers. Third Session of the Fifth Legislature of the Province of Ontario, "Report of the Inspector of Prisons and Public Charities, upon Hospitals, 1886." Vol. xviii. - Part vi. (Toronto : Warwick & Sons, 1887), p. 48.

hospital in the province."<sup>19</sup> Indeed, over the next two decades the Inspectors had no complaints on how the Hospital was run.

Although the financial situation of St. Joseph's Hospital fluctuated, over its first two decades, what remained fairly stable were its sources of revenue. It received the annual grants from the Provincial Government, under the Charity Aid Act, and from the Municipal Government. There were patients who paid for their hospitalization from the first year of its operation, and donations were also received; in its bi-annual report of December 26, 1884, it had received \$850 from patients and \$110 in voluntary subscriptions.<sup>20</sup> The amount of donations fell during the depressed years of the 1890's, and, in 1897, no private donations were received. Indeed, the financial problems of the 1890's forced the hospital to look elsewhere for support.

In spite of the attempts made to stop patients being admitted from outside the Port Arthur boundaries, St. Joseph's was continually called upon to accept patients from the surrounding area. In 1893, the Sentinel charged

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<sup>19</sup> Sessional Papers. Fourth Session of the Sixth Legislature of the Province of Ontario, "Report of the Inspector of Prisons and Public Charities, upon Hospitals, 1889." Vol. XXII. - Part iv. (Toronto : Warwick & Sons, 1890), p. 65.

<sup>20</sup> Love, op.cit., p. 9.



that "they (the surrounding area) go on dumping every accident case on us, and every case of disease that they possibly can ... irrespective of what it may cost Port Arthur." <sup>21</sup> In support of the hospital, the newspaper suggested a redistribution of funds between the District and Port Arthur, and in 1894, the hospital received a \$100 contribution from Fort William.<sup>22</sup> In 1895 and 1897 donations were received from the County of Algoma, and in the years 1899, 1900 and 1901, the town of Fort William donated money.<sup>23</sup>

The following section deals with various aspects of St. Joseph's Hospital over its first twenty years of operation. Areas dealt with are: the daily cost of each patient, the financial history, the number of patients per year, where they came from, their nationality, the average age of patients, the ratio of males to females, the average number of days spent in hospital and the most frequent medical problems that were treated throughout the period.

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<sup>21</sup> Ibid., pp. 9, 10. Sentinel, November 24, 1893.

<sup>22</sup> Ibid., p. 10. Sentinel, February 27, 1894.

<sup>23</sup> Sessional Papers of the Legislature of the Province of Ontario. Annual Reports of the Inspector of Prisons and Public Charities, Hospital Reports, 1884 - 1908. All the statistics in the following section were based on this source. The Provincial Government presented its figures from the annual reports from hospitals, based on the year starting October 1st and ending September 30th. The Inspector of Hospitals checked hospital records to ensure accuracy.

The average cost of each person per day, from 1885 - 1900, was 53 cents but, one year during this period was far above average. In 1895, the cost per patient per day rose to \$1.20 which could be attributed to the fact that, although many costs remained fixed, there were fewer patients in hospital; the hospital had ordered supplies in anticipation of a normal number of patients. Over the next two years the hospital administration economized but no such drive could keep costs at the earlier level, and the average cost per patient per day in the early years of the twentieth century was \$1.15.

Profits from operation in its early years helped offset its losses in the 1890's; its average profit was \$1,057.75 in the 1880's whereas the hospital averaged a loss of \$336 annually in the 1890's. In 1899 the hospital broke even, and in 1900 it showed a small profit but was unable to repeat that success in the following years. Compared to other hospitals in Ontario the costs of running St. Joseph's were like any other except that, on an average, it paid more money for coffins and funerals. This reflects the transient type of patient the hospital treated.

In spite of the number of transients what was significant was the proportion of the revenue that came from payment by hospital users. In the 1880's, one-third came from this source which was considerably higher

than the Toronto General Hospital or the Kingston General. Briefly in the early 1890's this ratio dropped to one-tenth but, by 1897 it had picked up again to one-third, rose to one-half by 1900, and then to three-quarters a few years later. These figures coincided with the change in attitudes towards hospitals; they were no longer institutions dedicated only to the treatment of the "sick poor".

As the 1895 financial statements showed, the number of patients in hospital per year varied. In the 1880's, the average was 120, and the rise to 165 patients in 1892 affected the planning for later years. Instead, the number dropped drastically to 70 in 1895. At the turn of the century the numbers were increasing steadily — 215 in 1899, 363 in 1900, 427 in 1901 and 631 in 1903. After the new extension of 1904 - 1905, over 1,000 patients were treated annually which reflected the growth of the town.

In 1900, a small wing which was not justified by population figures was added on to St. Joseph's. The 1901 census showed Port Arthur smaller than it had been in the mid-1880's, and for the first time, smaller than Fort William. This expansion could possibly have been related to the interurban rivalry, and St. Joseph's primary position in health care. It had been the only hospital at the Lakehead since 1884 but, the rapid rise

of Fort William, and the establishment of a Cottage Hospital there in 1898 indicated that its primacy was about to be challenged. The large three-storey wing added in 1904-5 was based on more economic reality, and perhaps also the emergence of McKellar General Hospital at Fort William.

Residence or place of work were listed for each patient admitted, and less than half came from Port Arthur. Over half of the patients from 1884 - 1892 were listed as having come from the "Canadian Pacific Railway", "Other Parts of the Province", or "Other Countries". After 1892, the railway was not mentioned but the District of Algoma was; this district had also contributed money to the hospital in the mid-1890's. The Cottage Hospital in Fort William had been established in 1898,<sup>24</sup> but it only had room for six to ten patients, and it soon became apparent that it was too small. With the boom in elevator building, and the rapid rise in population, it meant that once again facilities had to be found for the injured and sick workmen; hence the over-

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<sup>24</sup> J.M. Gibbon, Three Centuries of Canadian Nursing (Toronto : MacMillan Co. of Canada Ltd., 1947), p. 319. There were many isolated communities that were not serviced by hospitals or nurses. In response to this need Lady Aberdeen, the Governor - General's wife, established the Victorian Order of Nurses in 1898. A special voluntary fund was set up to provide for the establishment of Cottage Hospitals in remote areas. Thereafter, forty such hospitals staffed with two nurses and a maid, and able to accommodate six to 10 patients, were established throughout Canada.

flow from the Cottage Hospital went to St. Joseph's Hospital in Port Arthur. In 1899, 130 of the 215 patients admitted to the hospital came from Fort William; in 1900, 235 of 363. During these years the town of Fort William had contributed money to the hospital.<sup>25</sup> After 1903, however, when Fort William opened the John Mckellar General Memorial Hospital, patients from Fort William were treated there.

The "nationality" of patients were listed as either Canadian, English, Irish, Scotch or Other Countries (not specified as to which). About half were listed as Canadian; most of the rest were British, with only a small minority from Other Countries. During the 1880's, and 1890's the nationality of the patients in hospital was representative of the ethnic composition of the town — most people being Canadian or British. After 1900, with the construction boom in Port Arthur and Fort William, and the subsequent need for labourers, the ethnic composition of the towns changed. However, the ethnic mix in hospital was not clear since St. Joseph's Hospital records never specified which "Other Countries" patients came from, nor, indeed, did the Toronto or Kingston General Hospitals.

In 1900, at St. Joseph's, of the 363 patients treated 177 were Canadian, 132 British and 54 from Other Coun-

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<sup>25</sup> Sessional Papers, op.cit., 1884 - 1908.

tries — this was 14.87%. At the Toronto General 2.36% of the patients came from Other Countries and at the Kingston General, 1.05%. At the Toronto General of the 3,250 patients treated, 2,070 were Canadian, 992 British, 177 American and 77 were listed under Other Countries. At the Kingston General of 1,335 patients, 1,134 were Canadian, 161 British, 24 American and only 14 from Other Countries. Both the Toronto and Kingston Generals had a larger ratio of Canadian patients than did St. Joseph's.

The average age of patients at the hospital, throughout the 1880's, was 30.8, in the 1890's, 32.3, and in the early 1900's, 30.<sup>26</sup> The ratio of female to male patients averaged about one-quarter. In contrast, this ratio at the Toronto and Kingston General Hospitals was about one-half. There were no births at St. Joseph's until 1900, when there was one; thereafter, there was a steady rise of maternity cases; 5 in 1901 and 6 in 1903. There were more births at the Toronto and Kingston Generals but after 1900 the ratio of births per number of female patients at St. Joseph's rose close to those of the other two hospitals:<sup>27</sup>

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<sup>26</sup> St. Joseph's Hospital of Port Arthur Patient Registers, for the years 1884 - 1906.

<sup>27</sup> Sessional Papers, op.cit., 1884 - 1908.

Percentage of Births Per Female Patients

Date	St. Joseph's	Toronto General	Kingston General
1900	2.5	8.5	6
1901	5.6	8.2	6
1903	6.3	9.4	5.4

Again, this was indicative of the general change in attitude towards hospitals.

The average number of days spent in hospital remained fairly constant at 31.3 days per patient. The patients who were in hospital for a long time, over 100 days, suffered from a few general categories of diseases. One vague diagnosis was debility which simply meant generalized weakness. Another category was injured limbs such as fractures, dislocations, frozen or amputated limbs. Burns were another reason for long-term treatment as were infections, and ulcers of the skin. Finally, and not the least important were lung infections like pneumonia and tuberculosis, of which there were not many cases.<sup>28</sup>

Diagnoses were simple in part because of the type of patient admitted, partially because of a general lack of knowledge of specific problems and partially because of the isolation from southern Ontario. For example, in the 1880's, next to injuries one of the most common diagnoses was debility which did not

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<sup>28</sup> Patient register, 1884 - 1906, op.cit.

describe what was wrong with the patient. Another diagnosis, which appeared less frequently, was dropsy which meant edema. Again, this was a symptom of more serious problems that were not diagnosed. Inflammation of the lungs was another broad diagnosis not categorized. Often a diagnosis was sore eyes, sore leg or sore arm with no further indication of what was wrong.

There was no breakdown for operations in the patient register although amputations were mentioned. Surgery would have been confined to amputations, and emergency surgery for injuries and broken bones. There was also at least one case of gunshot and stab wounds annually which would have required surgery. Tumors were diagnosed but there was no indication as to whether they were removed. It appeared that abdominal surgery was first performed in the late 1890's. In 1897 there was one patient admitted with appendicitis, and the patient lived which would not have been the case had surgery not been performed. In 1898, four patients were admitted with appendicitis of which one died after one day in hospital; the appendix likely ruptured before or during surgery. The other three patients lived which indicated that surgery had been performed. Another problem, found in women, was endometritis which called for a surgical treatment called curettage; this diagnosis also appeared in the patient register in the



late 1890's.

The fact that Dr. Smellie was on staff at St. Joseph's throughout the 1880's raises some question as to how precise the recording was in the registers. Having come from Fergus Dr. Smellie would have known a very progressive medical man named Dr. Abraham Groves. Both men were the same age, although Dr. Groves had graduated from medical school in 1871. Groves set up a medical practise at Fergus, and developed quite a name for himself.<sup>29</sup> "[H]e kept abreast of changes in medicine and other sciences by constant reading, and by coaching medical students in the summer months, and learning from them as they learned from him." In 1874 he removed an ovarian tumor though he had never seen an abdominal operation while at school — he also sterilized his instruments. A few years later he has been credited with removing the first appendix taken out in Canada, having been inspired by an article written by a famous Birmingham doctor.<sup>30</sup> Groves continued operating, and since Dr. Smellie's parents lived in Fergus he would have kept in contact with them, and, likely, with Dr. Groves. Because Dr. Smellie was progressive in the field of public health does not

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<sup>29</sup> Hugh Templin, Fergus, The Story of a Little Town (Fergus : The Fergus New Record, 1933), p. 306.

<sup>30</sup> Ibid., pp. 306, 307.

necessarily mean he was a progressive surgeon, but it would be fair to say that he must have been influenced by Dr. Groves.

Although smallpox victims were isolated at an Isolation Hospital, typhoid fever patients were treated at St. Joseph's. Throughout the 1880's the hospital averaged 14 cases of typhoid a year. In 1892, however, there were 49; in 1900, 56, in 1901, 88 and in 1903, 130 typhoid cases. There were only very occasional cases of other communicable diseases such as rheumatic fever, scarlet fever, and diphtheria. Being primarily childhood diseases, the children would, usually, have been isolated home or at the Isolation Hospital.

Throughout the 1880's the most frequent cases were typhoid fever, injuries, inflammation of the lungs, frozen limbs, skin ulcers and skin diseases, eye infections, soreness, rheumatism and debility. The most common causes of death were from injuries, such as fractures and broken bones, and inflammation of the lungs.

In the 1890's diagnoses became more refined. Instead of a general diagnosis, like inflammation of the lungs, lung diseases were broken down into specific diagnoses such as pneumonia, bronchitis, asthma or pleurisy. There were fewer cases of sore limbs, and debility as much more scientific diagnoses appeared. However, there

remained some catch-all phrases such as kidney trouble, dyspepsia (indigestion), or deranged stomach. In spite of the improved scientific diagnoses, which meant improved treatment, most people came in with the same problems as those in the 1880's. One change in the 1890's was the appearance of alcoholics being treated in hospital; their numbers increasing towards the end of the decade.

In the 1890's fewer people died of injuries like breaks or fractures, the most frequent killer was lung problems. In 1892, 9 of the 49 typhoid fever patients died. In 1900, however, only 4 of the 56 typhoid patients died, and in 1901, only 7 of the 88 died; in 1903, 9 of the 130, which indicated better treatment.

After 1900, with the new-wings added, the profile of the types of cases treated in hospital did not vary significantly. Diagnosis was more scientific but, generally, there was just more of the same problems. The fact that women were entering hospital to have their children, or to be treated for "female problems" indicated a positive change in attitude towards hospitals. Also, the fact that diagnoses were more sophisticated meant that it was not just injured, disease stricken labourers who were entering hospital for treatment — a change was occurring. However, throughout the 1880's and 1890's, St. Joseph's Hospital of Port

Arthur was truly a reflection of the community catering to a transient workforce, and the "sick poor".

St. Joseph's Hospital lagged behind some of the southern Ontario hospitals in terms of sophistication of diagnoses; this can be seen in all the Reports on Hospitals in the Sessional Papers from 1884 - 1909. If, indeed, the patient registers were an accurate record of the operations performed at St. Joseph's, then it would be fair to say that the hospital also lagged slightly behind in the types of surgery performed. During the 1880's surgery remained quite primitive even at larger, well established hospitals such as the Toronto General, and Kingston General. Indeed, until in 1890's operating rooms were called "amputating theatres". However, during the 1890's, with the advances in medicine, surgery became more specialized. In the year 1890 - 1891 the surgeons at the Toronto General performed 47 operations for cataracts, 35 laporotomies for ovarian and uterine disease, 11 operations for prolapse of the uterus and 1 appendectomy.<sup>31</sup> Throughout the decade abdominal surgery became more common place. In contrast, at St. Joseph's Hospital Port Arthur, the diagnosis of appendicitis did not appear in the patient register until 1898 and cataracts until 1899.

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<sup>31</sup> W.G. Cosbie, The Toronto General Hospital, 1819 - 1965 : A Chronicle (Toronto: MacMillan Press Ltd., 1975), p. 113.

Hospitals such as the Toronto General and Kingston General, however, had been in existence longer, and had a larger permanent population to draw from. Both hospitals had medical students, and its own nursing school by the 1880's, so could also staff larger concerns. The Toronto General had started to specialize into different departments in the 1880's, and quickly became a research centre. St. Joseph's Hospital, on the other hand, serviced a small frontier town. Although the population of Port Arthur grew steadily after 1900 the hospital continued to lag behind the larger medical centres in the newest techniques and innovations. However, this did not mean that, generally, treatment was inferior. The Inspector of Hospitals noted that, "the work that is done in some of the smaller hospitals of Ontario is equal to that of any of the metropolitan institutions anywhere."<sup>32</sup>

One aspect of care at St. Joseph's that became critical, after the expansion in 1900, was the need for more nurses. As a result, the hospital opened a Training School in 1904. By the time this school was being planned the Sisters had thirty years of experience to draw upon, and organized their Nursing School according to the standards set in southern Ontario. Women, however,

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<sup>32</sup> Sessional Papers. First Session of the Twelfth Legislature of the Province of Ontario, upon Hospitals, "Report of the Inspector of Prisons and Public Charities upon Hospitals, 1908." Vol. XLI. - Part IX. (Toronto : L.K. Cameron Publisher, 1909), p. 6.

did not flock to the School for various reasons. St. Joseph's lagged behind some southern Ontario hospitals because of the nature of the community. Port Arthur did not have the population density to allow the hospital to specialize or become a research centre. Although there were signs that other people were entering hospital for treatment, it continued to function as a facility for the newly arrived workforce that needed care after accidents or when ill. Furthermore, the fact that typhoid fever and tuberculosis cases were treated in the hospital meant that it would be considered not only a tough but, potentially dangerous place to work.

Christina Banks, who was one of the first two nurses who worked at the Cottage Hospital at Fort William, mentioned that they had difficulty finding girls to do housekeeping because of the fear of working in a hospital.<sup>33</sup> Even Dr. Smellie proved not to be very progressive when his daughter made it known that she was determined to become a nurse. He had wanted Elizabeth to attend St. Margaret's College in Toronto when she graduated from high school in Fort William. Elizabeth graduated from the Training School of John Hopkins Hospital in Baltimore, but her father had done his best to dis-

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<sup>33</sup> Christina Banks, "Care of the Sick in Fort William", Daily Times - Journal (April 17, 1908).

suade her from going.<sup>34</sup> There was only one student admitted to St. Joseph's Training School in August 1904, and she spent more time away from the school than in it and never completed her training due to her father's illness. In May 1905, 5 pupils were admitted; 4 nuns and 1 lay woman. In 1906, 3 pupils were admitted; 1907, 4; 1908, 6, and in 1909, 5.<sup>35</sup>

The Training School was organized in the same fashion as other schools in Ontario. It was a 2,5 year apprenticeship course with a three month probationary period before admission to the school, at which time the pupil received her uniform. The student nurses worked twelve hour shifts; they would work the day shift for a period of time then the night shift. They were allowed one free afternoon during the week, and time off for church on Sunday morning. The students rotated through the various wards of the hospital including the operating room and the dispensary. Occasionally, the students went to nurse patients in their homes or were lent to the Isolation Hospital. They lived in the nurse's residence under strict rules of discipline.

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<sup>34</sup> Mary Machean, "Colonel Elizabeth Smellie", Thunder Bay Historical Museum Society. Vol. III. (Thunder Bay : Thunder Bay Historical Society, 1975), p.17.

<sup>35</sup> Elizabeth Regan, Training School of St. Joseph's Hospital 1904 - 1915, pp. 1 - 43. Miss Regan was the Superintendent of the Training School during this period, and she kept a record of each student.

The student nurses received lectures from physicians on bacteriology, contagious diseases, materia medica, obstetrics and gynaecology, major and minor surgery, anatomy and physiology, eye, ear, nose and throat problems diseases in children, preventative medicine, chemistry and laboratory, medicine and care of the teeth. Elizabeth Regan taught bandaging, and other nurses taught courses in domestic sciences, including dietetics, and practical nursing. The students were expected to attain a mark of 75% on all their exams. They were also given a general proficiency grade, and a monthly report, the grades of which were averaged over the 2,5 year period.<sup>36</sup>

The fact that women were reluctant to become nurses at Port Arthur was justified in view of the number of students who became ill during training. Most of the student nurses, in the first six years of the school, became ill; 3 with typhoid fever, one of whom had to leave permanently; one got chickenpox and another suffered from tonsillitis; the other student illnesses were not specified.<sup>37</sup> Although the Training School might have experienced difficulty in recruitment, and although the hospital was not highly specialized, the standard of training received at the Training School of St. Joseph's Hospital was of a high calibre. Two of the Graduate

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<sup>36</sup> Ibid., pp. 1 - 43.

<sup>37</sup> Ibid., pp. 1 - 43.



Nurses from this early period went on to become Superintendents at other hospitals, and another went to Ottawa to do post-graduate studies.<sup>38</sup>

The case study of Port Arthur, a remote and very new community far from the research centres and the most advanced techniques of diagnosis and treatment, showed how the community acted upon the experience of motherland and province precisely because it developed later.

In one sense, the early history of St. Joseph's can be seen as the late 19th century hospital system in microcosm, but the particular characteristics of the community influenced its development. The patients treated were often transient males, and the opportunity for care in the home was less than in settled communities. The ethnic mix of the community also differentiated it from most southern Ontario centres. Moreover, the rivalry between Port Arthur and Fort William had significant effects on the development of health care.

In terms of institutionalization, the expansion of St. Joseph's in 1900 came at a time when there was talk of a new hospital at Fort William because the Cottage Hospital there was too small. The Training School was opened in 1904, the same year McKellar General opened its school, at a time when there were not enough students to warrant one school. In addition, both towns had a board of health. It would have

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38 Ibid., pp. 1 - 43.

been far more efficient and economical had there been but one hospital, one training school and one board of health.

Rivalries between communities in Ontario, as in England (as in the case of Leeds and Bradford) sometimes stood in the way of the efficient management of resources.

## Chapter VI

### Overview

A crisis in health care in Britain was brought about by the industrial revolution. The increase in urban populations led to a rise in plague diseases, such as cholera and typhoid fever, due to overcrowding and improper sanitation. Until 1848, there was no scientific understanding of the causative agents of communicable disease but the Sanitary Reformers knew something passed from sick people to cause illness in others and campaigned for sanitary reforms. The first Public Health Bill passed in 1848, authorized the formation of a Central Board of Health; however, this Board was disbanded in 1854, primarily for political reasons.

Public awareness and concern for sanitary conditions were heightened during the Crimean War and led to a permanent Public Health Act in 1875 (and amendments thereafter).

Another reform of the mid-nineteenth century dealt with the better regulation of the medical profession but did little to improve medical care for the "sick poor". In terms of reform of hospitals and nursing care, Florence Nightingale played a major role and the Crimean War marked the watershed. During the second half of the nineteenth century scientific developments in all aspects of medicine furthered the cause of improved health care in Britain— also available overseas.

On attempting to explain the fact that there was so much uniformity in health services apparent by 1900, it seems that

industrialization itself provided the key to the puzzle. It created the problems in health care in the first place, and the necessity for solutions. It also created the joblessness in Britain that led many citizens to emigrate; it created new methods of transportation (steamships by the 1830's), a demand for compulsory education, a rise in literacy rates and a proliferation of newspapers and magazines that made possible the creation of public awareness of issues. In fact, a study of the spread of health care services can be viewed as British imperial development in microcosm.

There were many reasons why the colony of Upper Canada was affected by changes in Britain. An important fact was that it was already in existence at the time of mass immigration in the first half of the nineteenth century; it was almost entirely English-speaking so no linguistic or cultural barrier prevented migration itself or the transmission of ideas. A Loyalist province, moreover, was more likely to look to Britain for its ideas than to the United States. Britain can thus be viewed as a source of both ideas and problems for the colony.

In Upper Canada public health issues were brought to the fore by waves of immigration—the result of British changes as the unemployed sought a new life in the colony. One has only to reflect upon those thousands who obtained cheap passage on boats which had carried lumber to Britain and would otherwise have returned empty (minimal cost in currency, maximum cost in human suffering). An issue that

exacerbated the problems experienced at the Grosse Isle Quarantine Station was the fact that the Canadian government tried in vain to get Britain to assume the total cost of caring for immigrants who became ill during transit. The resultant public health issues and hospital development were more closely connected than in Britain, the first hospitals being used to isolate immigrants with communicable diseases.

In Upper Canada, the influence of the Sanitary Reformers in Britain can be seen in the Act of 1833, which established Boards of Health with the authority to deal with sanitation problems as well as other public health issues. This Act put Upper Canada ahead of Britain with regard to legislation, but the Act was weak in that it was only in force for one year. Permanent, preventative maintenance of public health was not considered necessary at this time.

Inadequate and unscientific medical care, the deplorable conditions in hospitals and limited nursing care (although not nearly as bad as in Britain) all contributed to the primitive state of health care in Upper Canada during the first half of the nineteenth century. After 1860, however, the situation changed dramatically in Ontario with new ideas, skills and research being adapted from Britain. The medical profession was becoming more scientific and, therefore, more credible. With the increase in the number of hospitals and the trend to hospital specialization came the need for well-trained nurses. The first Training School was opened in St. Catharine's General and Marine Hospital in 1874. Two

Nightingale nurses from Britain were hired to organize the training programme, and standards were set for the schools that were opened thereafter.

Although revolutionary changes in medical services came about during the second half of the nineteenth century, the idea that public health — in terms of clean towns, pure water, proper sewage and garbage removal, better housing and personal hygiene— required constant care to prevent disease took a long time to be accepted.

Yet sanitary reform and public health legislation did progress in the last three decades of the nineteenth century. After 1873 diseases of all kinds decreased substantially at the Quarantine Station in Quebec. The fact that the dreaded cholera was no longer a major threat did not mean that other diseases did not prevail. Ontario was plagued by outbreaks of smallpox, diphtheria, typhoid fever and tuberculosis. As a result, a Public Health Act which contained measures for sanitary purposes and established the authority to carry them out was passed in 1873. Again, it seemed that Ontario kept pace with Britain in public health legislation. Nevertheless, the fact that in most instances such legislation was not carried into effect was evidence of neglect and reflected a poor attitude towards the necessity of permanent public health measures.

By 1882, however, sanitary reformers in Ontario had met with success as the Ontario Board of Health was established in that year. One of the first things the Board did was to

send a circular to the clerk of every municipality to see whether the council had organized a local board of health under the Act of 1873 — the results were shocking. The Board then set out to find out what was wrong and discovered that the primary reason why there were so few local boards was that municipal councils had been given a choice; the idea of compulsion had been deemed unacceptable.

It was argued that the only way to achieve a high standard of health was through the acceptance of public health measures which could only be achieved by educating the general public through articles in newspapers, periodicals, pamphlets, sanitary conventions, public lectures and the co-operation of doctors, teachers and the clergy. However, after two years the Ontario Board of Health recognized it was not making enough progress and that legislation based on some principle of compulsion was required. In 1884, after much debate both in and out of the legislature, a comprehensive Public Health Act was passed under which the formation of local boards of health became compulsory.

The Public Health Act of 1884, followed by amendments leading to the Consolidated Health Act of 1887 and amendments thereafter, formed the basis of public health legislation in Ontario. However, the primary weakness in the system remained the reliance on voluntary adherence. Co-operation continued to be sought through increased knowledge rather than the strict enforcement of the law on a continual basis. Notwithstanding, in 1901, the Ontario Board of Health

assessed its first twenty years of existence and reported that much progress had been made in the field of public health.

The influence of the Ontario Board of Health and the Sanitary Reformers can be seen in the case study of Port Arthur. Since local boards of health only used the law to enforce public health legislation when absolutely necessary — during threats of epidemics — how responsive any community was to the requirements of the Provincial Board depended upon the concern of people in influential positions. Although not the only interested individual, Dr. T.S.T. Smellie provided the dynamic leadership throughout the 1880's. The Port Arthur Board of Health with the co-operation of the Municipal Council took the role of the Provincial Board seriously and carried into effect a high standard of sanitary reform. Unfortunately, Dr. Smellie left Port Arthur in 1890, due to the economic downturn, and the Board of Health went into a slump.

An epidemic occurred in 1892 that forced a reorganization of the Board with the help of Dr. Peter Bryce, a representative of the Ontario Board. Dr. Macdonell was replaced as the Medical Health Officer by Dr. J.S. Beck who managed to maintain the sanitary condition of Port Arthur at an acceptable level throughout the 1890's. In spite of the problems faced by the Port Arthur Board of Health in the early 1890's, the Board responded quickly to advances made in southern Ontario and maintained a high level of sanitation.



Sanitary reform was not the only health care issue addressed by the town of Port Arthur in the last two decades of the nineteenth century. With the improved economy and the increase in population of Prince Arthur's Landing in the early 1880's, as a result of the construction of the Canadian Pacific Railway, the need for a hospital became imperative. A system in which injured or sick workmen were sent to boarding houses or relied on the charity of individual families for care could no longer support the numbers needing help.

While influential community leaders were debating the feasibility of a General Hospital, the Sisters of St. Joseph's began to operate a temporary hospital in the new wing of their convent in February 1884. The building of a permanent facility gained considerable public support as the burden of caring for sick or injured workers was lifted. St. Joseph's Hospital was formally opened in 1885, and operated efficiently over the next twenty years. In many respects, St. Joseph's kept pace with hospitals in southern Ontario such as the Toronto and Kingston Generals. However, as these hospitals began to specialize throughout the 1890's, St. Joseph's lagged behind in the newest techniques and innovations although this did not mean that, generally, treatment was inferior. Furthermore, when St. Joseph's opened its Training School in 1904, it drew on the thirty years of experience from other schools in Ontario and set high standards.

The case study of a small, isolated community in northwestern Ontario - its history, its Board of Health, its Hospital and its Training School - compared to larger centres in southern Ontario, illustrated how quickly ideas were disseminated. Indeed, although Ontario might have lagged slightly behind Britain in terms of public health, hospitals and training schools, the medical profession did keep abreast of what was happening in Britain. Since most immigrants came from Britain during the first half of the century, they often brought with them negative attitudes towards doctors, hospitals and nurses. However, the revolutionary changes in all the health care fields in the latter half of the nineteenth century brought about much needed reform. Professional, and public education in Ontario (and a remote town in the province) improved quite rapidly to adapt to the new scientific medicine being practised in Britain.

In spite of the similarities, there were also differences between the British experience and its Canadian colony. Crisis conditions in health care had developed earlier in Britain, but reformers had required a great deal of political support and awareness on the part of the upper classes to bring about change.

Even as they developed, Ontario cities and town did not have slum areas comparable to those of England. This could be attributed to the low population density and the relative space. Further, when disease manifested itself, the whole

community was aware of its presence and its threat, whereas in Britain the upper classes were far removed from what was happening in the slums. Consequently, there was a sense of urgency and crisis when epidemics appeared in Ontario. Nevertheless, the fact that the need for permanent health care was slow to be accepted could be attributed to the British tradition the colony absorbed which was a concept of individual freedom that would be in conflict with the new regulations health authorities came to demand. The debates in the Ontario Legislature during the 1880's over compulsory legislation clearly illustrate this problem faced by public health reformers. A more egalitarian frontier society was less likely to accord deference to "upper class" professionals who claimed expert knowledge. Nonetheless, the positive note of progress made in public health by the turn of the century was indicative of what was to come — the Ontario public did come to expect and demand a high standard of health care.

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