**'WE'LL SEE YOU NEXT YEAR': MATERNITY HOMES IN SOUTHERN
SASKATCHEWAN IN THE FIRST HALF OF THE TWENTIETH CENTURY**

by Laurel Halladay, B.A.

A thesis submitted to the Faculty of
Graduate Studies and Research
in partial fulfilment of the requirements for the degree of
Master of Arts
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of the Twentieth Century"

submitted by Laurel Halladay, B.A.
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the degree of Master of Arts

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ABSTRACT

This thesis examines the role that maternity homes played in southern Saskatchewan during the first half of the twentieth century. The focus is on maternity homes established during the interwar years in small Saskatchewan communities by women who operated them both as a business and as a service to the community. These homes provided medical care for pregnant women who wanted to leave their place of residence for childbirth but were prevented by distance from going to public hospitals. For the women who operated them, the homes were both a means of making a living and a way of achieving status in the community.

The primary research on which the thesis is based includes personal interviews, local histories, and government documents. The thesis includes a brief summary and analysis of late nineteenth-century Canada, and concludes with an analysis of the process whereby southern Saskatchewan interwar maternity homes were gradually phased out during the development of provincial health care programs in the 1940s.

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For Pioneer Women

Mary Bradley Bryant

Amy Nutall Leslie

Laurel Bryant Valentine

Randee Valentine Halladay

and

Bessie Marjorie Leslie Halladay

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Chapter One - Introduction

This thesis intends to place maternity homes on the continuum or time line of the transition from home to hospital births, from the turn of the century to the late 1950s. The definition of a maternity home includes any private health care service made available by an individual woman and primarily dedicated to the childbirth of both married and unmarried women. I have separated maternity homes in Canadian history into two basically distinct groupings, either first era or second era homes. First era homes appeared as an arm of the social reform movement in the urbanizing areas of central Canada in the mid-nineteenth century. In response to a general fear of rapid change, the popularity of the Eugenics movement, an interest in 'science' and great disparities between classes, the middle and upper classes organized to provide increasingly medicalized maternity services for 'fallen' women, the pregnant unmarried and the poverty stricken. First era homes are then greatly informed by the class and regional disparities resulting from industrialization. The middle and upper classes could better afford to keep their own illegitimate births¹ from the public

¹This paper's discussion of first era maternity homes relies greatly on the historic Anglo-Saxon concept and definition of illegitimacy which treated children born out of wedlock and their mothers with great societal disapproval. Because the idea of illegitimacy was so tied to the predominantly European culture, this discussion will naturally not include

view by hiring midwives to come to their homes or by going to a relatively distant expensive private maternity home. Consequently, first era homes were primarily focussed on working class unmarried women and on those that were seen as being in need of social assistance by well-meaning charities.²

In contrast, second era homes, the prairie maternity homes that are the main focus of this thesis, appeared largely after the social reform movement had receded and grew in number during the Depression and the early war years. Evidence of maternity homes appears as early as 1895 and as late as 1963. These homes were largely in the rural areas of western Canada where significantly sized populations demanded maternity care but were not large enough to initially draw doctors into the community on a long term basis and later to provide a substantial tax base to build a hospital. Demand for maternity services increased following the immigration boom to the west after 1896 and the care provided by maternity

members of ethnic communities who did not share this negative view of unmarried mothers and their children.

²Concern about rising levels of illegitimacy seems to have been largely a product of urbanization, as large numbers of women migrated to the urban centres, leaving family support networks in rural areas. While the negative effects of the socio-economic transformation of this era were felt by the working class, women within this class were especially affected. Women in urban areas were "offered little support and security...work was difficult to find, living conditions were crowded and miserable and loneliness seemed to have been a rule of life." Illegitimate births then increased as a result of this unpleasant situation for women, who looked for solace outside of wedlock. This theory, of course, neglects to include instances of sexual assault, etc. that resulted in pregnancy. Patricia Tomic-Trumper, "The Care of Unwed Mothers and Illegitimate Children in Toronto, 1867-1920: A Study in Social Administration" (Ph. D. thesis, Department of Education, University of Toronto, 1986), 33-34.

homes meeting this need was less informed by class and enjoyed by a more ethnic diverse group of users and owners. These homes appeared later than in the east and existed longer because of slower urbanization and industrialization in a newly settled region, conditions that also changed their operation somewhat from their eastern forerunners.

Research on the second era homes is directed specifically at those in the southern Saskatchewan area³ in the first half of the twentieth century. The historic emphasis in this region on the wheat staple, the unique patterns of settlement, leftist political sentiments, ethnic and religious diversity and the early appearance of socialized health care make Saskatchewan the ideal territorial location for such a study. The southern portion of the province will be used to geographically limit the study to those areas first settled and in the greatest concentration of population.

In addition, because of the available sources of information, this research is focussed mainly on the 1930s and 1940s, a time span in which health care and how it was delivered came under increasing scrutiny in the province. The Depression period and the drought of the 1930s were followed by the war years. Together they provide a framework that allows one both to explore the history of maternity homes in the prairie region and, more specifically, to examine how these homes changed in bleak economic times and under the

³See Appendix 1 for a map of this area.

pressures of world war. As well, because migration and immigration to the region slowed at this time, the ethnic mix during the 1930s and 1940s remained relatively stable and thus the influence of ethnicity will be limited to that of first and second generation immigrants exclusively.

There is a decided lack of sources on prairie women in the interwar decades. "Publications on women in the prairie west are heavily concentrated in the settlement period, from the 1880s to the 1920s; earlier and later periods are very thinly represented."⁴ Unfortunately, the bulk of second era homes appear after this period and thus formal information on them is scarce.

There is a considerable amount of information on the history of Saskatchewan as a province. John Archer's Saskatchewan: A History and J.F.C. Wright's Saskatchewan: The History of A Province, for example, are helpful in contextualizing the historic political and economic climate in the area.⁵ Work that focusses more specifically on the social aspects of Saskatchewan and its residents is less common. C.A. Dawson's and Eva R. Younge's Pioneering in the Prairies

⁴Susan Jackel, "Canadian Prairie Women's History: A Bibliographic Survey" The CRIAW Papers, NO. 14 (Ottawa: Canadian Research Institute for the Advancement of Women, 1987): 6.

⁵John Archer, Saskatchewan: A History (Saskatoon: Western Producer Books, 1980) and J.F.C. Wright, Saskatchewan: The History of A Province (Toronto: McClelland and Stewart, 1955). For more general histories of the prairie region, see Gerald Friesen, The Canadian Prairies: A History (Toronto: University of Toronto Press, 1984), J. Arthur Lower, Western Canada: An Outline History (Vancouver: Douglas and McIntyre, 1983) and A.W. Rasporich, ed., Western Canada: Past and Present (Calgary: McClelland and Stewart, 1975).

and Seena B. Kohl's Working Together are the main contributions in this area.⁶ Literature pertaining to the history of health care in the province is more abundant, although it does tend to be pre-occupied with the role of doctors in the Saskatchewan Medical Care Insurance Act of 1961.⁷ Women's history in Saskatchewan, outside the study of the battle for suffrage, is dominated by a handful of scholars. Ann Leger Anderson, Eliane Silverman, Susan Jackel, Candace Savage, Angela Davis and Georgina Taylor, among others, have greatly contributed to the history of Saskatchewan's women and prairie women in general in a number of different areas.⁸

6C.A. Dawson and Eva R. Younge, Pioneering in the Prairie Provinces: The Social Side of the Settlement Process (Toronto: The Macmillan Company, 1940) and Seena B. Kohl, Working Together: Women and Family in Southwestern Saskatchewan (Toronto: Holt, Rinehart and Winston of Canada, 1976)

7Two dominant examples are E.A. Tollefson, Bitter Medicine: The Saskatchewan Medicare Feud (Saskatoon: Modern Press, 1963) and Robin Badgley and Samuel Wolfe, Doctors' Strike: Medical Care and Conflict in Saskatchewan (Toronto: Macmillan of Canada, 1967).

8Anderson has done a great deal of work on Saskatchewan women's historiography, see for example "Saskatchewan Women, 1880-1920: A Field for Study," in H. Palmer and D. Smith, eds., The New Provinces: Alberta and Saskatchewan, 1905-1980 (Vancouver: Tantalus Research, 1980), as has Eliane Silverman in such work as "Writing Canadian Women's History, 1970-1982: An Historiographical Analysis," Canadian Historical Review 63, No. 4 (December 1982). Susan Jackel's work invariably lets the voices of the women themselves come through in such sources as her introduction to Georgina Binnie-Clark's Wheat and Women (Toronto: University of Toronto Press, 1979) and in her editing of A Flannel Shirt and Liberty: British Emigrant Gentlewomen in the Canadian West, 1880-1914 (Vancouver: University of British Columbia, 1982). Candace Savage, after her work on Foremothers: Personalities and Issues from the History of Women in Saskatchewan (n.p., 1975), was part of the team that produced the first widely-read book on prairie women, A Harvest Yet To Reap: A History of Prairie Women (Toronto: The Women's Press, 1976). Angela Davis has focussed on farm women in such articles as "'Country Homemakers': The Daily Lives of Prairie Women as Seen through the Woman's Page of the Grain Growers' Guide, 1908-1928," in Donald Akenson, ed., Canadian Papers in Rural History volume VIII (Gananoque, Ont.: Langdale Press, 1992) while

A more recent contribution to the study of women in Saskatchewan encapsulates the literature in the above areas and has developed a chronology of stages through which the topic area has evolved.⁹ Aileen Moffatt describes three predominant eras in the literature. The first stage of "celebratory" history was popular from the 1930s to the mid 1970s. This stage saw women in Saskatchewan as "helpmates to men, or as 'great' or 'noteworthy' individual women." From the mid 1970s to approximately 1990, the second stage contributions tended to "examine women as a group (usually prominent, white, English-speaking women only) and often located women within the separate spheres paradigm." Finally, work done in the 1990s has become more diverse and includes "theoretical developments in literary criticism, anthropology, cultural and ethnic studies."¹⁰

According to Moffatt's stages then, this study is part of both the first and second stage in that it is both devoted to 'noteworthy' individuals and depends on a 'separate spheres paradigm' while dealing with a distinct women's culture. Because it is largely descriptive in nature, it lacks new

Georgina Taylor has written on farm women's activism in "Equals and Partners: An Examination of How Saskatchewan Women Reconciled Their Political Activities For the CCF with Traditional Roles for Women" (MA Thesis, University of Saskatchewan, 1983).

⁹Aileen C. Moffatt, "Great Women, Separate Spheres, and Diversity: Comments on Saskatchewan Women's Historiography," in 'Other' Voices: Historical Essays on Saskatchewan Women, David DeBrou and Aileen Moffatt, eds. (Regina: Canadian Plains Research Centre, 1995): 10-26.

¹⁰Ibid., pg. 10-11.

theoretical development. It is also fairly non-exclusive in terms of any non-white ethnic group's contribution and participation. While this research may not be in keeping with the current trend in Saskatchewan women's historiography, it is an attempt to fill in some of the gaps left by historians of the first and second stages.

Three main sources were used for the research done on second era homes, namely personal interviews, local history books and government documents. The initial stage of research involved writing letters to the editors of seven small town newspapers in southern Saskatchewan.¹¹ Community newspapers are popular in rural areas because they allow subscribers to keep in touch with events and issues in their region. The towns and villages targeted by these seven newspapers span the width of the province and were subject to a number of variables in their history that may have influenced the appearance and operation of maternity homes. For example, these concentrated areas of settlement bridge territories that were either primarily involved in wheat or mixed beef cattle/grain economies. They were also representative of areas in close proximity to Native reservations, other historically close-knit ethnic groups, such as French-Canadians, Germans and Ukrainians, and the American border.

¹¹Letters to the editor were sent to The Maple Creek News, The Carlyle Observer, The Estevan Mercury, The Assiniboia Times, The Shaunavon Standard, The Radville Star and The Gravelbourg Tribune. See Appendix 2 for a copy of the letter as it appeared in the above newspapers.

As well, the towns in the far east and far west are very close to the Manitoba and Alberta borders. By looking at maternity homes that operated in remarkably different areas, any commonalities found between compared homes can be generalized to others more accurately.

The majority of people who responded to my call for information concerning prairie maternity homes were women. By the beginning of May 1995, I had received over thirty letters from women who had run a home with their mother or other close relative, worked in a home over a number of years or had children in such a facility. In June, CBC Radio Regina contacted me to do an interview on the subject and several more letters volunteering information came in after the broadcast. While I might have thought that I had sufficient contacts in the province to begin interviewing from the letters alone, many of the women who responded encouraged others to whom they were somehow related to write and soon I had many personal interviews scheduled for July and August in both Saskatchewan and Alberta.

Once in Saskatchewan, I met and was referred to several more people who had some experience of maternity homes. Getting more spontaneous interviews in a small town or out in the country in Saskatchewan is far less difficult than one from an urban centre might assume. The open nature of community in rural Saskatchewan, some residual spirit of boosterism that results in a willingness to talk about the

community with amicable 'outsiders' and the small scale of settlement allows access to a wide scope of information. For example, waitresses in the local restaurants, gas station attendants and store managers are generally excellent sources of information and willing to direct a researcher to other people in the area with some knowledge of the topic. Those people do the same and soon the researcher has a virtually complete picture of the subject in that particular region.¹²

The twenty-six tape recorded interviews I conducted in southern Saskatchewan were almost exclusively with women, exceptions arising in three instances when husbands were present and had made contributions to the interview.¹³ At times, daughters, granddaughters and nieces were involved in the interview, asking questions of their own and prompting the memories of the participants. Much preparation was spent in readying myself to do the interviews I felt were necessary in exploring this topic. Attitudinal adjustments were essential; I had to call up prairie colloquialisms, points of information, common political sentiments, greetings and any common personal ground in order to have answered the questions

¹²This sort of research is called 'snowball sampling'. While sometimes criticized for what is perceived to be its inherent bias, this kind of sampling seemed extremely appropriate for "a numerically small group with well-developed patterns of social organization." Raymond Lee, Doing Research on Sensitive Topics (London: Sage Publications, 1993), pg. 66.

¹³Oral testimony utilized in this study comes from a set of interviews conducted by and in the private collection of the author. See Appendix 3 for a list of participants, as well as the locations and dates of interviews.

I was asking. Any perceived distance between myself and the participant had to be addressed, for example, by explaining where my family was from and why I was using a tape recorder.¹⁴ Part of my attitudinal adjustment involved changing the format I would normally use to get information from a subject. In interviewing, I allowed the discussion to evolve organically, not pushing, but letting honest interest play its part in gathering information. In any case, the major points of information I wanted to glean from the interview were spelled out in the letter to participants (see Appendix 4) which most subjects read immediately upon our meeting and these questions would be addressed by the respondent eventually. Often the participant would guide me to important information that I had not thought of asking for. The quality of information gained through these rather informal interviews lends credence to the claim that "...the standardized interview, with its closed questions and rigid pre-specification of topics, does not enhance disclosure but precludes it. In the case of women, feminist writers argue the survey interview objectifies female experience and mutes

¹⁴It is not a cliché to say that the people I interviewed were shy of any unfamiliar technology. While I had initially ruled out using a laptop computer during interviews, I found it necessary to tape most of the conversations I had. Clues within the social setting often provided a way to explain away the need for the tape recorder. "I'm a bit forgetful so I hope you don't mind if I use this recorder. I'll need to listen to our chat again later - and it's a good souvenir of our visit" became my usual slogan. While these elderly women may or may not have empathy for forgetfulness, it seems appropriate when drinking tea from a Regina Agricultural 1986 Exhibition mug, for example, to desire a souvenir.

woman's self-expression."¹⁵

Because the experience of childbirth represented a major event in the lives of many of the participants, it was necessary also to get a picture of each person's entire life. My research subjects related this information without hesitation. Details of their own birth and marriage, the lives and growth of their children and grandchildren, often the death of their spouses and their current social activities all became as important in the interviews as the topic of maternity homes. During many interviews, the respondent and I spent considerable time looking over family photographs and discussing recent community developments. This information, far from being extraneous to the topic, helped me to construct a context in which I could place the development of maternity homes. Much of what I have learned from these women will not be included directly in this thesis but is nonetheless important to the way in which I present the material.

Another valuable source for this study was the collection of local histories,¹⁶ housed in the Prairie History Room at the Regina Public Library. These histories were generally produced to mark the jubilee of Saskatchewan as a province or the centennial of the town in question. In all cases, government funds were made available to defray costs of

¹⁵Raymond Lee, Doing Research on Sensitive Topics, pg. 108.

¹⁶See Appendix 5 for a bibliography of the local history books relevant to this study.

production and thus keep at a minimum the charge to those in the local area. For the most part, these history books do not contain special sections on the role that midwives and maternity homes played in the community. However, information, largely biographical, on these women can in many cases be found under their family name. As these sections are usually submitted by family members, any exploration of a woman's maternity home business is direct proof that, at least within the extended family, the contribution to the community was perceived as important enough to be recorded. Invariably, when the woman never married, her 'family' history is separated from her extended family with the word 'Nurse', as in Nurse Susie Penner (Waldheim) and Nurse Jean Scott (Cupar). That a historical look at these women, most of whom never had formal training, would include the formal recognition of their career and talents is telling.

Several local histories contain chapters on the history of the area's union hospital and an examination of the doctors who served the district only, or mention a maternity home in passing. Notable exceptions to this less than conspicuous salute to maternity home operators can be found. Why some history committees chose to set aside separate chapters and sections on the subject can only be a matter of speculation. Perhaps those on the committees had direct contact with such women, or the town had several maternity homes or was extremely late in getting a local hospital. In any case, the

existence of separate histories on this subject within these history books shows that certain communities chose to fully acknowledge the role these women played in delivering health services. Some sections, interpreting the phenomenon in a romantic fashion, are entitled "A Tribute to Courage and Trust" (Strasbourg), "Ministering to Body and Soul" (Pangman) and "A Heroine of the Northwest" (Lafleche) for example. Other histories paint maternity homes as a further sign that Saskatchewan residents, while lacking some formal institutions like those in other areas of Canada, made do quite well in providing medical services to the area's residents. Such sections are labelled "Hardships: Lack of Medical Care" (Foam Lake), "'The Good Will Hospital': An Oasis in the Dry Thirties" (Hepburn) and "Nurse and Aid in Time of Trouble" (Lafleche). The business aspect of maternity services are in the fore when the subject can be found in sections titled "Community Services and Recreation" (Cadillac) or "The History of Businesses" (Delisle). That maternity homes were viewed as an advance on home births and an intermediate step before hospitals is obvious in sections discussing all three situations in a category named "The History of the (Town) Hospital". Still others discuss maternity homes after sections on "Doctors", "Dentists", "Druggists", "Chiropractors" and "Optometrists" in a section simply named "Nurses". It would appear that, in these areas, maternity home owners were viewed as just part of a spectrum of health

care deliverers, albeit, in hindsight, on the bottom of the stack. Indeed, their interdependent involvement with other medical care officials is obvious in the most common manner of including a discussion of maternity homes, a title of "Nursing Homes and Doctors" or "Nursing Homes and Hospitals". While the local histories, like the interview participants, usually neglected to mention unpleasant occurrences, they were an invaluable source for detailing the history of a region and maternity services in that region, as well as in determining the social, economic and professional status of maternity home matrons within the region's historical context.

Government documents provide the third major source of information in researching southern Saskatchewan's maternity homes. This evidence is primarily statistical and anecdotal. The bulk of the information on this topic is found in the ten year period from 1935 to 1945 when the partial governmental funding that had, in some cases, become necessary to support the services provided by maternity homes during the Depression evolved into complete administrative control at the provincial level. The statistical portion of the available information comes from the Department of Health's Annual Reports. I have used some of their conclusions concerning birth, infant mortality and maternal mortality rates and formulated tables that coordinate a number of various figures as they relate to maternity home operations. The anecdotal evidence comes from two types of correspondence; that from the Health Services

Planning Commission (HSPC) and the Department of Health to the homes' matrons and that between the Division of Public Health Nursing and the matrons. The character of archival material originating with the Department of Health and the HSPC is more authoritarian and less helpful than that from the Public Health Nurses who met the matrons in person during their annual inspections and so I have focussed more closely on the Nurses' inspection reports and the matrons' applications for operating licenses. The major drawback of governmental sources is that, by detailing only those homes that came into contact with the government (and the majority would have eventually) they do not give the full picture of maternity home operations in southern Saskatchewan. Government archives also have virtually no information concerning those homes operating before the Depression.

This study has certain serious methodological limitations. First, I do not intend to look at motherhood in its entirety and will focus on the process of delivery at the expense of issues of pregnancy, child care, fertility, birth control, adoption, etc. At the same time, by focussing specifically on childbirth, I do not mean to imply that it is women's only relevant status. One cannot divorce reproduction from women's other equally relevant roles. While an examination of the birthing process in isolation from these surrounding factors is both undesirable and impossible, the emphasis is necessary in order to thoroughly explore the

locations in which women had their babies and what that has meant to the process itself. Because the way in which a given group conducts childbirth involves a cultural manipulation of a natural process, a look at the influential sociological factors of the time will address these issues in an indirect manner. It will become apparent that cultural conditions affect other issues of motherhood in a way very similar to that of actual birth.

Secondly, like many examinations of women's history, this study will be rather non-inclusive in terms of race. While modes of operation in certain eastern maternity homes outrightly excluded certain ethnic groups, the scant records that exist on this topic are of course dominated by European women's words, values and experiences. In addition, those people who responded to my call for information were exclusively of European origin. Where appropriate, I will include racial aspects of the topic and generalize from the extent that non-European women were involved in maternity homes.

Thirdly, the terminology surrounding maternity homes is problematic. What women on the prairies called a maternity home would be called a cottage hospital in Newfoundland (a hybrid of a formal hospital and maternity home), a lying-in hospital in Ontario and a maternity hostel in Quebec. While these terms go a great distance in indicating where on the medicalization continuum these central and western Canadian

establishments should be placed, I have generally reviewed their operation and then compared it to my definition above. Only those that fit the definition have been included in this study.

The transition from home to hospital births relies greatly on the medicalization of childbirth and the imposition of science on the process of delivery. Science began to affect childbirth largely in the mid-eighteenth century in the colonies of British North America. Fear and anxiety on the part of women in childbirth during this period contributed to the demand for scientific intervention in this natural process, as "doctors appropriated, and to some degree, women relinquished control over childbirth."¹⁷ Maternal and infant mortality was high - most women had knowledge of other women and their babies dying or being seriously injured during birth. In addition, "postpartum gynaecological problems...caused some women extreme discomfort and disability throughout the rest of their lives." These fears of death and disability led women away from traditional birthing practices toward new procedures that appeared to lessen their risk.¹⁸ It would seem that parturient women had, because they were actively looking for some relief from pain, fear and anxiety,

¹⁷Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," in British Columbia Reconsidered: Essays on Women, eds. Veronica Strong-Boag and Gillian Creese (Vancouver: Press Gang Publishers, 1992), pg. 143.

¹⁸Judith Leavitt, "'Science' Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century," Journal of American History 70(2) (September 1983): 283.

a significant amount of agency in the medicalization of childbirth that is overlooked in many historical studies concerning childbirth. Most telling is the fact that once a woman had a doctor for a delivery and regardless of how that delivery had proceeded, she would be unlikely to resort to a midwife to assist her. Indeed, after delivering one baby, a doctor could be assured of demand for medical services from the entire family over a long period of time and thus a guaranteed income.¹⁹ Though women in the eighteenth and nineteenth century made decisions for themselves based on their choices and resources, the repercussions of this medicalization, though undergoing some modifications today, had very predictable patterns, largely because of the social and cultural applications of the technology. "'Science' as a human enterprise pretends to disassociate itself from specific cultural themes...but...its hidden stances exemplify social preoccupations."²⁰ The different scientific technologies used in birth and the manner in which they were used was largely a matter of class during the gradual transition from home to hospital births. The forceps for example were generally for the upper classes, though poor women were used as manikins for medical school lectures on the topic. Because forceps

¹⁹Margot Edwards and Mary Waldorf, Reclaiming Birth: History and Heroines of American Childbirth Reform (New York: The Crossing Press, 1984), pg. 149.

²⁰Ann Oakley, Women Confined : Toward a Sociology of Childbirth (New York: Schocken Books, 1980), pg. 70.

demanded formal training for their use, traditional midwives were excluded from using them and only learned men were allowed to own and employ them in difficult births. Thus lower-class women who could not afford physicians were not allowed to enjoy the benefits that forceps brought to a compacted labour. This is especially true for unwed mothers around the turn of the century in whose case "physicians often rationalized the withholding of medical knowledge on moral or religious grounds as well as on medical."²¹ Likewise, the use of opium, laudanum, ether and chloroform depended greatly on the ability of the women to pay for such products. In a great number of ways, the middle and upper classes encouraged the medicalization of birth and the transition from birthing in the home to birthing in the hospital, although the lower-classes were used for the practice of training physicians and seemed to reap proportionately less of the benefits of the technology. While the middle and upper classes could afford these technologies in their own homes and then in hospital when it appeared safer than giving birth at home,²² the working class and poor went to charitable institutions and dealt personally with their fear, pain and anxiety.

Many would agree that the basic tenet of science in

²¹Wendy Mitchinson, "Historical Attitudes Toward Women and Childbirth," Atlantis IV (1979), pg. 15.

²²In Canada, middle and upper class women only started to go to hospitals in the late 1930's after the introduction of sulpha drugs in 1937 made hospital birthing as safe as home delivery. C. Lesley Biggs, "The Response to Maternal Mortality in Ontario, 1920-1940" (M.A. Thesis, University of Toronto, 1982).

childbirth was and is a power over nature. In this way of thinking, the scientific practitioner is likely to conduct some sort of interference in a natural process in order to express that power. It was necessary in order to prove one's skill as a doctor. In the medicalization of birth, the temptation to interfere was perfectly acceptable in dealing with parturient women. The womb was thought to be the key component of femaleness - control the reproductive function and the woman is controlled. Indeed if the womb was the core of womanhood, it was also the site of and responsible for her inferiority and thus should be taken over for the good of the woman herself and society in general. So because the veneration of science demanded interference with nature and natural processes, it is the cultural manifestations of this interference that is of concern in looking at maternity homes. While childbearing as a natural experience of women could be thought of as unifying among all eras, classes and regions, the event occurs under extremely varied social circumstances.

Before the turn of the century, the imposition of class on reproduction more than any other factor determined where and with whom women would give birth. Put bluntly, the amount of money one had access to determined where one would give birth. Because medical locations outside the home were associated with disease and poverty in the early nineteenth century, middle and upper class women endeavoured to give birth at home with a midwife or physician and often both. It

was well known through studies of maternal and infant mortality rates that, in the early years, the risk involved in birth was not significantly higher for midwife-assisted births than for doctor-delivered hospital births.²³ As the medical profession was popularly perceived to have gained more knowledge about birth (largely from their experiments in those establishments providing services for the lower classes), and science was seen to have conquered nature, it became more popular for the upper classes to request doctors to assist them during confinement. Indeed, doctor-assisted births became a status symbol for the upper classes because they represented progress and scientific achievement.²⁴

This transition occurred in different ways depending on country and region. For example, the move from home to hospital births occurred in a different period from that of the United States. Likewise, western Canadian circumstances acted on the transition in a way distinct from that of central

²³In central Canada, for example, "rigorous studies have shown that the massive intrusion of doctors in obstetrics between 1900 and 1930, the period of the elimination of midwives, did not decrease the peri-natal mortality rate." Helene Laforce, "The Different Stages of the Elimination of Midwives in Quebec," in Delivering Motherhood: Maternal Ideologies and Practices in the Nineteenth and Twentieth Centuries, eds. Katherine Arnup, Andree Levesque and Ruth Roach Pierson (New York: Routledge, 1990), pg. 47.

²⁴Of course, where and with what kind of attendant one would give birth was determined more by the reality of the birth process than by advance planning. Assistance in birth depended greatly on geographical distance, availability and the particular circumstances of the birth itself. For example, if a woman had planned on being attended by a midwife but suffered some sort of complication, a midwife would likely call upon the assistance of a doctor. Thus the midwife could possibly avoid blame for the death or disability of the parturient woman while giving her additional medical help.

Canada. Keeping this general chronology of the gradual imposition of science on childbirth in mind, first and second era homes can be discussed and positioned on the continuum from home to hospital births in Canada. While Chapter Two will discuss what role maternity homes in central Canada played in moving births from home to hospital, Chapters Three and Four will explore how the maternity home evolved in the prairie region under much different conditions and what role they played in determining the predominant location of childbirth. Chapter Five will contextualize maternity homes and their owners in the local, regional and provincial realms and describe their disappearance while Chapter Six will point out some conclusions and areas that need further research.

Chapter Two

In order to provide contrast for the second era homes which are the main focus of this thesis, their historic antecedents must first be explored. First era homes in central Canada around the turn of the century provided prairie women with a precedent in women-delivered health care. Most pre-Confederation birthing homes in Upper Canada were organized to deal with the incoming populations; immigration, in that it coincided with a growing industrialization, meant an early need for medical services. In Upper Canada, following the huge influx of pauper emigrants in 1832, poor relief services were established. First among them was a "Lying-In hospital for pregnant women, which was recommended by the Upper Canada Medical Board owing to the 'destitute condition in which many arrive'."²⁵

The legal foundation of first era maternity homes in English-Canada was established in Ontario, and this foundation necessitated a clarification of the different types of maternity homes. The primary literature on this topic in this early time period includes three overlapping areas of service. Public maternity homes, like those specifically mentioned thus far, were operated by both religious and secular charities and

²⁵Rainer Baehre, "Paupers and Poor Relief in Upper Canada," in the Canadian Historical Association's Historical Papers (1981): 63-64.

were seen to be the best option in the eyes of the state. Private maternity homes were run by private citizens for personal profit. Thirdly, the derogatory term 'Baby farm' is sometimes used in reference to private maternity homes that offered various types of adoption services in addition to maternity services and other times used to mean infants' homes that were not sanctioned by either charitable organization or the state. 'Baby farms' were thought to greatly contribute to the infant mortality problem by killing the unadopted and thus expensive babies of unwed mothers. While there is perhaps some truth to this assumption (data on the operation of 'baby farms' is lacking),²⁶ the close association of these terms does in some cases mask the beneficial aspects of private maternity homes, a point I will elaborate on further below.

Descriptions of private maternity homes in urban Toronto provide us with an idea of central Canadian first era maternity homes in general.²⁷ Not surprisingly, details of

²⁶The only exception to the lack of records on 'baby farms' concerns the Ideal Maternity Home in East Chester, Nova Scotia. In operation from 1925 to the late 1940's, the Ideal Maternity Home provides an example of those private maternity homes that actually did operate as a 'baby farm'. Though information on the home is sketchy, it appears that the home was open to primarily unwed mothers whose babies were either sold to American couples or died under unnatural circumstances. The story of the Ideal Maternity Home and the woman who ran it were recently the subject of a CBC television production. Bette Cahill, Butterbox Babies (Toronto: McClelland-Bantam, Inc., 1992).

²⁷Licensed maternity homes were inspected regularly and the following details come from the inspection reports of the Toronto Board of Health. It is difficult to generalize based on these reports as the number of licensed homes was quite small in the early years. In 1898, four homes were inspected for purposes of licensing while ten were checked in 1906. Other private maternity homes were examined based on complaints made by private citizens (the Board of Health was required to investigate any charges made) but there are no records of the conditions found in these homes. Patricia Tomic-Trumper, "The Care of Unwed Mothers," 80-81, 162,

these homes are largely constructed around the task at hand - providing a discreet location for a working class woman to have an illegitimate baby. Private maternity homes were owned and operated by working class women, often widows, and thus were usually located in very unsafe and poor buildings in working class areas. The lower and working class women who used these homes were generally in their early twenties and perhaps were less patronized by those operating the home because of a similar class consciousness. Inmates of first era homes usually came to stay in the home months in advance of the birth, emphasising the need to conceal their unfortunate circumstances. Conversely, women would generally leave as soon as possible after the birth in an effort to secure gainful employment and make up for lost wages. This need for employment also demanded that women leave the home without their children as employers were reluctant to hire single mothers and homes often attempted to arrange adoption for unwanted children. The living conditions in private maternity homes varied depending on the proprietor. The few that were run by trained nurses tended to be more upscale, a situation that owners could control by letting in only those women who had some financial support from the fathers of their babies. Other were less comfortable:

Situated in the meanest quarters of the city,
these old, tumble-down buildings do not make
the most healthful of summer resorts, the warm

weather arousing all the germs of disease that may exist in the surroundings. In the winter, the meagre heating apparatus which the home contains finds it impossible to diffuse a necessary warmth throughout a building into which both wind and snow obtain admission without much seeking.²⁸

It is difficult to conclude whether the owners of these sub-standard private maternity homes were consciously taking advantage of women who could ill afford to go elsewhere or whether the inferior quality resulted from a simple lack of the material resources required to provide more comfortable surroundings. That such homes were commonly associated with 'baby farms' assumes the former.

The assumption that all private maternity homes were potential 'baby farms' became the impetus for legislative control of private maternity services. Throughout the industrializing years following 1893, discussion of maternity homes focussed completely on the infant at the expense of the mother. This preoccupation with the infant (the product) over the mother (the producer) develops greatly in the early years of the twentieth century, largely as a consequence of the "shift from home birth to hospital birth, and with increased intervention during the process of childbirth."²⁹ Ostensibly concerned about and motivated by the rising infant mortality

²⁸This quote comes from a discussion of the detrimental effects of private maternity homes in The Mail, January 27, 1887.

²⁹Anne Queniat, "Risky Business: Medical Definitions of Pregnancy," in Anatomy of Gender: Women's Struggle for the Body, eds. Dawn H. Currie and Valerie Raoul (Ottawa: Carleton University Press, 1992), pg. 163.

among both legitimate and illegitimate babies,³⁰ legislators began a series of public actions aimed at the evils of 'baby farms' and thus private maternity homes in general. I would argue that the state had ulterior motivation in instituting legislative control. First, as members of the upper, elite classes, law-makers had a vested interest in keeping their collective eye on the working class. Controlling the circumstances in which they gave birth was a logical way to do so. Secondly, legislation applicable to private maternity homes also allowed them to have control over the birthing process itself and thus women in general, a key component in the move from the private home birth to the public hospital birth. In any case, it is such legislation that ensured private maternity homes would be retained in the historical record.

The laws affecting private maternity homes appeared in the decade after Confederation but little was done by provincial and municipal governments to control them until 1893. Under the 1893 Children's Protection Act of Ontario because of their presupposed connection with orphanages, maternity homes were subject to visits and inspections at any time by the Superintendent of Neglected and Dependent Children. Chapter 258 of the Act includes three guidelines

³⁰In 1900, one in five babies in Ontario died before its first birthday. Cynthia Abeele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1918-1940," Ontario History 80(3) (September 1988), 183.

for homes operating in the province. First, "maternity houses (are) not to be kept unless registered. Second, "births in houses (are) to be attended to by (a) physician. Finally, Section 26 concerns adoptions of children from the maternity home itself. Strangely, this section is not elaborated on extensively.³¹ This Act seemed ineffective to most in the prevention of infanticide and was reinforced by the 1897 Act to regulate Maternity Boarding Homes and for the Protection of Infant Children. This Act speaks to the perceived connection between 'baby farms' and private maternity homes in that it "required that houses where infants were being boarded and cared for apart from their natural mothers be supervised by a Medical Health Officer."³² Dr. Charles Sheard, Medical Health Officer for the Toronto Board of Health, argued that these changes did not go far enough in regulating the operation of private maternity homes and 'baby farms':

Maternity houses must be licensed (and)...opened for bi-weekly inspection. The keepers of these places should have no jurisdiction over the infants. Their profits end with the accouchement of the inmates. A register should be kept in each house, in which the name and address of every patient, the day of her admission and departure, and whence she goes, should be entered.³³

By-laws to this effect were passed in Toronto in May of the

³¹National Council of Women, Women of Canada (published for distribution at the Paris International Exhibition, 1900), pg. 319-320.

³²Patricia Tomic-Trumper, "The Care of Unwed Mothers," 154-155.

³³The Mail and Empire, November 7, 1897.

following year, making it "the only city in the province which has put into force the Act regulating private maternity hospitals and infants' boarding places." Four convictions were filed before the end of 1898.³⁴

This particular legislation finally produced the reform law-makers were looking for. By 1900, the city required the profit-driven private maternity homes to have such high standards in order to be licensed that they virtually could not compete with charitable hospitals and the lower classes began to look there for maternity services. Public maternity homes were eligible for government grants and were seen to have more resources than private maternity homes. However, those homes that operated under very bad circumstances and conditions were able to remain open illegally. Thus, while the switch to hospitals from private maternity homes was thought to have had a favourable affect on infant mortality and abandonment, the legislation only affected homes that were at least marginally acceptable while the worst continued to operate. Legislation passed in 1911 failed to change this result as it was basically a rewording of the 1897 Act.³⁵

First era maternity homes were thus established for better or worse by the time settlement levels in western Canada demanded similar services for women there. After about 1920, direct intervention by government in the affairs of

³⁴Patricia Tomic-Trumper, "The Care of Unwed Mothers," 156.

³⁵Ibid., 174.

illegitimate children and their mothers in central Canada meant charitable organizations had largely lost control of maternity services. Western Canada was still in its infancy while these developments in maternity services took place. Only the first urban areas in the west, such as Winnipeg, had established public maternity homes. "Settlement of the prairies was fairly slow during the 1870s and 1880s, when Canadian land policy and climatic conditions combined to make the Canadian west less attractive than competing American frontier areas" but after 1896, immigration to the west began to increase and would continue to do so until the outbreak of World War I.³⁶ Until the population grew more concentrated in the post-war years, farm women were primarily assisted in labour by family members and neighbour women acting as midwives. Because doctors initially went to areas with a significantly large and localized population like Calgary or Winnipeg, some prairie women went for decades without consistent help from the formal medical establishment.³⁷ Indeed, "health care services on the prairies in 1900 were limited to twenty hospitals and a few dozen nurses and physicians; many settlers relied on home remedies and lay care

³⁶Richard Pomfret, The Economic Development of Canada (Scarborough: Nelson Canada, 1989), pg. 147. Pomfret claims that "the main regional loser from the high tariff policy was the prairies" (86) and thus the 1879 National Policy meant that industrialization and some respite from successive boom and bust periods occurred later in the west.

³⁷By 1935, "28% of Canadians were living in the 20 cities with a population of 30,000 or more. Yet these city dwellers were served by 45% of the physicians." Cynthia Abele, "'The Mothers of the Land Must Suffer'," pg. 185.

givers."³⁸ Marion Dudley Cran's A Woman in Canada, written in 1910 following a Dominion government requested tour of the west to determine opportunities for women, established this fact by calling for nurses:

And at last I found what I felt all along must exist; a hardship to be faced which make women justly shrink from the country...I heard a cry about the hardships of birth on the homesteads...Myself a trained maternity nurse as well as a mother, I know what lack of skilled attention must mean at the hour of travail. Doctors, of course, are necessary; wholeheartedly I repeat necessary at confinements, but every doctor and every mother knows that the nursing which follows after his duties are over have a tremendous part to play in recovery.³⁹

Interestingly, Cran also laments the "exorbitant fees" charged by nurses (who prefer "fever or accident work") for maternity care and refutes the fact that general hospitals were amalgamating with maternity homes by arguing that "the general hospitals are in nearly every instance averse to maternity wards. They say, and quite justly, that maternity work should have a separate building and staff."⁴⁰

In general, women on the prairies had several 'options'

³⁸Ina Bramadat and Marion Saydak, "Nursing on the Canadian Prairies, 1900-1930," Nursing History Review I (1993): 105.

³⁹Marion Dudley Cran, quoted at length in A Flannel Shirt and Liberty, ed. Susan Jackel (Vancouver: University of British Columbia Press, 1982), 142-143.

⁴⁰Ibid., pg. 143. Two years earlier in 1908, the provincial health officer for Saskatchewan had made a similar comment on the reluctance of hospitals to take maternity cases. He stated that "in some of the hospitals visited, I found that not a single maternity case was taken care of during the year; in fact...such cases were not admitted, it being against their rules. I think the sooner such rules are changed, the better." Department of Agriculture, Annual Report 1908, pg. 218.

in childbirth that depended greatly on their particular conditions of farm and frontier life. They could deliver their babies at home, by themselves or with help from their older children, husbands and neighbours. Midwives, who were sporadically available across the prairies, were sought after if one was to have a baby at home. They would come before the labour began, assist in delivery and then stay for as long as three weeks, cooking, cleaning and running the house. Midwives, too, would often take produce and livestock in payment and free services were not unheard of. Home births were most common, especially in the immediate years following immigration, if the homestead was far from a town centre or if the family was from a non-English speaking country. In the crucial first years, any available money was usually spent on the homestead rather than for health services.

For those that had come from the United States, the United Kingdom or from eastern Canada, it was sometimes possible to return there for the due date and be in familiar surroundings. This option of course was restricted to those with the financial resources to do so:

I was born in England. There were no doctors out here, so my grandfather sent the money out and told Mother to come home. The family were worried about the delivery's being out here, so Mother had the Queen's physician to take care of her. I was over there until I was six months old.⁴¹

⁴¹An anonymous source from Eliane Silverman, The Last Best West: Women on the Alberta Frontier, 1880-1930 (Montreal: Eden Press, 1984), 70.

Conversely, it was not unheard of for a woman's mother or sister to come from the east or the U.S. to assist in the delivery.

An increasingly prevalent option was the private maternity home. It is clear that farm women had come to western Canada to build communities for themselves and their families. Maternity homes were part of this construction, as were schools and churches. Two conditions allowed for the appearance of private maternity homes in the prairie region. First, a number of women had come from central Canada and had been cognizant of the operation of maternity homes in Ontario and Quebec.⁴² While homes in the west were modified somewhat, they were based on the example set in the east. Secondly, while the Ontario government was taking up responsibility for social welfare programs from charitable organizations, the lack of provincial jurisdictional action in Saskatchewan created a gap in maternity services that western private entrepreneurs slowly embracing industrialism were quick to fill. As a result of these two conditions, private maternity

⁴²It would stand to reason then that some women from eastern Canada had preconceived notions as to what a nursing home on the prairies was. Alma Miller pointed out that maternity homes in eastern Canada had a different reputation than those in the west in a story about a woman who had come from the east:

...there was no way she was going to a little meagre nursing home. She had made plans to go to Regina. Anyway, everything happened very quickly as it was her first child, and she had to go to Mrs. Evans' home. Well, would you believe it? She had three or four after that and she went to Mrs. Evans' for each of them.

Mrs. Alma Miller, interviewed by the author, tape recording, Carlyle, 5 August 1995. Mrs. Miller gave birth to a son in Mrs. Evans' nursing home in the mid-1940s.

homes specific to the needs of western Canadian women began to appear.

It is with these second era maternity homes that this thesis is primarily concerned. I intend to divide the study into three areas of investigation; those who owned the homes and/or worked there, those who used maternity homes, and lastly, the complex roles maternity homes played in their communities and in a province moving rapidly toward socialized medicare.

Chapter Three

A demographic profile of those operating maternity homes is necessary to determine under what conditions and circumstances this birthing option was made available to women in rural Saskatchewan. Aspects such as the educational, ethnic, religious and class backgrounds of maternity home proprietors are essential as are their familial situations of motherhood and marital status. These entrepreneurs,

with few exceptions, largely share the same circumstances. Overwhelmingly, in both the city and smaller centers, they were Anglophones of European backgrounds, approximately three-

Figure 1 Edna Anderson (l) and Mabel Hultien with the Clausen twins in front of the maternity home in Midale, summer 1945.

quarters of whom were immigrants from the British Isles.⁴³ While there are examples of French-speaking matrons in the province, competition from the social infrastructure established by the Catholic church in areas of French-Canadian settlement meant there was little or no demand for privately run maternity homes.

Table 1

Number of Nursing Homes Inspected by the Department of Health, 1926-1944⁴⁴

1926	48	1935	38
1927	63	1936	31
1928	39	1937	72
1929	41	1938	68
1930	37	1939	105
1931	33	1940	116
1932	32	1941	151
1933	57	1942	107
1934	45	1943	104
		1944	97

⁴³All information from the "Report of Private Hospital or Nursing Home" GS 64, PH 5, File 40, Department of Public Health-Nursing Division, SAB. There may be a connection between the fact that most matrons were of British ancestry and the historic evidence of maternity homes in England from very early on. While different in certain aspects from their evolution in Canada, these maternity homes attempted to offer a safe and largely female influenced environment for women to deliver in. For more information on the historic version of British maternity homes, please see Linda Gordon, Maternity: Letters From Working Women (New York: W.W. Norton and Company, 1978) and Catherine Webb, The Woman With the Basket: The History of the Women's Co-operative Guild (London: self-published, 1927).

⁴⁴All information here comes from the Department of Public Health Annual Reports and includes inspected nursing homes only. The number of homes awarded a license would be smaller of course, but the number of inspections gives us a better, though still unclear, idea of just how many homes were operating, with or without governmental approval. It would appear that licenses were not often checked up on. From 1926 to 1932, nursing homes fall under the responsibility of Hospital Management. After that, they are in the jurisdiction of the Division of Maternal and Child Welfare, and Public Health Nursing. Records of inspections in the Annual Reports cease after 1946.

Maternity home owners were also largely of the lower to middle class. The manner in which most of the women got involved in this business, dictated by financial necessity, meant that day-to-day economic pressure for survival was at least the original impetus to open a home. Maternity homes rarely, if ever, made their owners well-off, especially for those operating in the 1930s. The best a matron could hope for was to keep her home and clothe and feed herself and her children. Thus upward class mobility was possible in terms of community status only rather than material wealth.

The educational backgrounds of the women who operated nursing homes is also largely a function of class. In a government list of nursing homes operating in 1938 province wide, only 31.18% were graduate nurses while 68.82% were operating with practical experience only.⁴⁵ In 1940, only a slightly greater proportion of these women, 39.18%, were formally hospital trained nurses.⁴⁶ So while many were not formally educated, they did often have a great deal of practical experience. Most had been midwives who would go out into the surrounding area and assist in deliveries for years, gaining status and prestige as a care-giver. By the time they had decided to set aside one or two rooms in their homes for

⁴⁵This is of the 93 homes listed as operating in 1938. GS 64, PH 5, File 40, Department of Public Health-Nursing Division, SAB.

⁴⁶Of a total of 97 homes listed on chart "Private Hospitals, Nursing Homes, Homes for Chronics, Aged and Infirm", GS 64, PH 5, File 40, The Department of Public Health-Nursing Division, SAB.

maternity patients, these women often had decades of experience and on the job training.

It is important to emphasize that despite the lack of formal schooling some of these matrons had, they definitely were not short on skills that were useful in southern Saskatchewan. Like most rural women, they were responsible for keeping farm accounts and some taught their children at home. Others had run hotels and rooming houses in urban centers before relocating to the country. Various other women sat on local committees as political figures while others had marketable talents like phone operating and hairdressing.⁴⁷ I would argue historical studies of women in this geographic area that view women's career options as limited to either teacher or nurse are misleading. While it is assumed that teaching and nursing were the only occupations allowed a woman in this time period, the less common but still prevalent nurse-practitioner or matron of a private nursing home had distinct advantages and independence in operating her own small-business. Many matrons conducted their businesses for years, far past retirement for other career women, and enjoyed making business decisions and collecting any profits. They could be married and have children while owning their own home. Teaching and nursing positions, on the other hand, did

⁴⁷Olga Proctor of Young, for instance, was a hairdresser and a matron during the same period. Her nursing home/hair salon must have truly been a women's space. Young Celebration Committee, Footsteps to Follow: A History of Young, Zelma and Districts, 1981, pg. 423.

not allow many of these luxuries. For predominantly unmarried and childless women, the development of these careers were largely in the hands of hospital and school boards which meant very little decision-making was left to the woman herself. Having much more mobility, teachers and nurses were billeted out and usually did not own their own homes. Marriage or pregnancy usually meant the immediate end of a teacher's or nurse's career. So while opening a nursing home may or may not have involved choice, matrons enjoyed both families and a career in a way that the two traditional occupations did not allow.

While religion is not often mentioned in relation to maternity home work, we can assume that because the ethnic background of most maternity home matrons largely reflected the ethnic mix in the province at the time, religious affiliation in the province as a whole would give an indication of that of maternity home matrons. In the southwestern portion of Saskatchewan, the population was predominantly Lutheran and partly Presbyterian. In the central area, around Gravelbourg and Assiniboia, the bulk of the settlers were Roman Catholic and Presbyterians. In the south-eastern section, from Weyburn to Carlyle, the population was almost evenly balanced between Methodists and Presbyterians.⁴⁸ We can assume then that nursing homes in

⁴⁸Donald Kerr and Deryck Holdsworth, Historical Atlas of Canada III: Addressing the Twentieth Century, 1891-1961 (Toronto: University of Toronto Press, 1990), plate 34. These religious affiliations are from the

these areas were operated by women more than likely to be affiliated to one of the more popular religions as discovered in the census.

Table 2

Married and Single Licensed Maternity Home Operators⁴⁹

	Married	Single
1933	74	34
1934	87	34
1938	62	18
1940	73	15
1943	65	9
1947	38	1

With a very few exceptions, maternity home owners were widowed and left with a family to raise on their own. In Table 2, we can assume a great proportion of the married women were actually widowed, though exactly what percentage is difficult to calculate. Ironically, for those women with formal technical nursing training, marriage often initially meant a pause in the progression of their careers as nurses.⁵⁰

1921 census.

⁴⁹Taken from the "Private Hospitals, Nursing Homes, Homes for Chronics, Aged and Infirm Classification of Cases", GS 64, PH 4, File 9(1940), PH 5, File 40(1938), PH 5, File 42(1943), R326, File 62(1947), R780.1(1933/1934). Marital status is taken from the prefix (Mrs. or Miss) used for maternity home operators, as it appeared on their license to operate. In cases, where no prefix was used, marital status has been determined through the woman's history in the local history book. If marital status is still not clear, they are not included in either category. Marital status is then taken at that point in time - single women could have married later and married women may or may not be widowed.

⁵⁰Mrs. Evelyn Walper, for example, had graduated from Saskatoon City Hospital with her Registered Nursing Certificate in 1919. "Plans for a nursing career were interrupted in 1923 when she and Bill were married quietly". The Womens' Institute - Delisle Book Committee, Through the

Predictably then, it seems that the death of the husband was an impetus to open a home and begin nursing again.⁵¹ One event often led directly to the other for women like Mrs. Esther Jarvis, who actually bought a good-sized house with her husband's life insurance money, a grand total of \$2500 in 1927 and shortly thereafter opened it to maternity cases.⁵² It is likely that being widowed played a less obvious role in establishing a home than that of supporting a family. To a great extent, these women's husbands died of an easily preventable and/or treatable illness. The partners of others were victims of accidental death, as in the case of Mrs. William Nye. This woman, whose entire family, including an infant, was drowned in the Titanic disaster that she had survived, "became a wife, a mother, and a widow all in the same year"⁵³ and settled in Conquest to open a maternity home that operated until the outbreak of World War I. That becoming a widow meant a greater demand for long-term independence is clear:

Years: Delisle and Donavon, 1973, pg. 211.

⁵¹Examples of this situation are plentiful. Mrs. Annie Willis, for one, moved herself and one daughter to Ceylon from Radville after the death of her husband in 1941 and operated the local nursing home for seven years. The History Committee of the R.M. of the Gap #39, Builders of a Great Land: History of the R.M. of the Gap #39: Ceylon and Hardy, 1980, pg. 110.

⁵²Muriel Jarvis, interview by the author, tape recording, Saskatoon, 31 July 1995. Ms. Jarvis' mother ran a nursing home in Kenaston.

⁵³Centennial History Committee, Proud Heritage: Conquest, Saskatchewan, 1968, pg. 159. With the start of the war, Mrs. Nye closed the maternity home and went overseas with the Red Cross. She eventually won a war medal for her services there.

She was alone for so many years and one lady said to her 'Well you wouldn't get a meal, cook a meal for yourself, would ya?' and she said 'well, I haven't been a widow for seventy years and not eaten'. She always cooked herself a good meal at noon. No, she never thought, I don't think, about getting married again. They used to tease her about some fella that was a bachelor and just about the same time, you know. She said well he has four of a family and I have four of a family and she said and then if we had four more that would be just about a dozen too many.⁵⁴

While a certain small number of entrepreneurs were single and childless, some were married and their male spouses played a large role in the operation of the maternity home. To a great extent, despite the presence of a male head of household, the maternity home was often the primary source of income for the family. The husbands usually assisted around the home and held transient, short term, jobs in the local area. Mrs. Lydia Evans recalls the division of labour in her marriage:

In the summer Tom worked at the Lake for Mr. Diamond, in the winter no work. I could not afford to hire help. Tom did washing, ironing, cooking, he made very good bread. After a while, he went to Flin Flon, stayed there two and a half years. He wanted us to go. By this time I was fairly well established in my Nursing Home and did not want to start in another town.⁵⁵

It would appear that while husbands of the nursing home

⁵⁴Bessie Hill, interview by the author, tape recording, Lumsden, 2 August 1995. Mrs. Hill is the niece of Mrs. Inglis, who ran a home in Lumsden.

⁵⁵Mrs. Lydia Evans (Carlyle and District Historical Society), Prairie Trails to Blacktop: Carlyle and District, 1882-1982, 1982, pg. 658.

operator were never in the actual delivery room, they did have some contact with the maternity cases the home had admitted. A Mrs. Schwebius, whose last three children were born at the Gillespie home in Landis, comments on Mr. Gillespie:

Mrs. Gillespie was the nicest woman I ever met. Mr. Gillespie was helpful in so many ways, too. He would walk about the house with the babies in his arms.⁵⁶

To some, it appeared that the husband of a married couple with a maternity home was actually the head of household despite the community focus being on the wife. Lydia Evans' husband, for example, apparently did not enjoy the same level of public profile that his wife did:

Tom Evans was one of the finest men you'll ever meet...he has to play a part in this. She got all the glory and the talk but he was the backbone and a wonderful, wonderful man. He was there all the time doing the work.⁵⁷

That some maternity homes were run as an obvious partnership, albeit with a division of labour based on skill, is clear by the roles Mr. and Mrs. Bradley played in their Cadillac maternity home:

Although Mrs. Bradley was quite deaf and wore a hearing aid in the daytime, she seemed to have a sixth sense and would waken if a baby cried. If, perchance, she did miss hearing

⁵⁶Landis History Book Committee, The Landis Record, 1983, pg. 129. Mrs. Dahl's husband Carl also lent a hand in her maternity business in Admiral by making cribs. Admiral History Book Club, Admiral: Prairie to Wheatfields, 1978, pg. 31.

⁵⁷Hazeldene Evans, interviewed by the author, tape recording, Carlyle, 23 July 1995. Mrs. Lydia Evans, the matron of the home in Carlyle, is Mrs. H. Evans' mother-in-law.

one, Lew was always there to waken her.⁵⁸

In some instances, for a variety of reasons, couples were geographically separate from each other and therefore the husband was of little assistance in the operation of the home. Mrs. Alice Monkhouse explains how different means of making an income influenced her marriage:

In 1939, we moved to Avonlea where I took over a maternity nursing home from Mrs. Mary Waddell. I ran this hospital in close association with Dr. Dunnet, bringing 900 babies into the world. I continued this until his death in 1957. My husband lived in town in the winter and farmed in the summer until his death in 1957.⁵⁹

In any case, whether a husband was present and what role if any he played in the operation of the maternity business, partners were almost never thought of as staff when maternity home operators responded to government inquiries. While maid/housekeeper, cook and "as necessary part time" positions were designated as staff extra to the matron, only in one instance was a husband identified as a staff member.⁶⁰

⁵⁸Mable Bradley (Cadillac and District History Book Association), Cadillac Prairie Heritage, 1987, pg. 72.

⁵⁹Alice Monkhouse (Avonlea Historical Committee), Arrowheads to Wheatfields: Avonlea, Hearne and District, 1983, pg. 420.

⁶⁰Jessie Aimer, who operated her maternity home in Saskatoon, identified her staff of two as including one graduate nurse and her husband, who did "heating and maintenance work". "Application Form for License to Conduct Private Hospital, Maternity Home, Rescue Home, Children's Home or Similar Institution" of April 2, 1934, GS 64, PH 5, File 42, Department of Public Health-Nursing Division, SAB. Males were sometimes hired as outside workers; Pete Baker was one such employee at the Hultien Nursing Home in Midale. When asked in for lunch, though, "he'd wave his arms and refuse, saying, "Too many women! Too many women!". This is an acknowledgment that nursing homes were largely women's domain. Cymri History Book Society, Plowshares to Pumpjacks: The R.M. of Cymri, Macoun, Midale and Halbrite, 1984, pg. 70.

Part of a maternity home operator's practical nursing experience usually included having given birth to children of her own. While none of the single women studied had children that were mentioned, virtually all the rest had delivered at least one child. Predominantly, these women had already had their families by the time they had set up the nursing home and even the youngest was old enough to lend a hand around the house. While the presence of children born in wedlock meant that a widowed woman would have to support them by earning a living, their occasionally untimely and usually young deaths also no doubt encouraged these entrepreneurs to provide adequate maternal and infant health care in order to avoid such an unhappy event in the lives of other women.⁶¹ Mabel Hultien of Midale, for example, lost six babies in infancy and another at a decidedly premature age.⁶²

At the same time, maternity home owners expected and generally received assistance from their children in the operation of the home, especially from the eldest and the daughters in the family. That the work was rewarding and the influence long-lasting is obvious by the high percentage of daughters who went on to be nurses themselves and invariably returned to give birth with their mothers assisting. Many

⁶¹Mrs. Jennie Allan for example, who operated a home in Preeceville, claimed that her "main incentive in starting a hospital was the loss of their first baby". Preeceville Historical Society, Lines of the Past, 1982, pg. 61.

⁶²Plowshares to Pumpjacks, pg. 327.

daughters went right into the delivery room at a young age to help their mothers in providing maternity services for the community.⁶³ Muriel Jarvis of Saskatoon, who herself went on to an extremely successful and distinguished nursing career, recalled being the eldest child in a successful maternity home:

I was thirteen the first time I assisted and it was a difficult, difficult one and it was a psychological bump! That would have been in 1933, that was one of the early ones. (My help) wasn't planned. The doctor and mom were having difficulties and he said we better get somebody to help us and who's around and mother said well Muriel's the only one, well she can help. I'd always wanted to be a nurse, for as long as I can remember. But it was difficult and we had a bad time resuscitating the baby...I thought that if mother survived that and I survived it, we could go through almost anything!⁶⁴

Conversely, some daughters of maternity home owners were not always enthusiastic about the business of delivering babies and their experiences there had a profound effect on how they viewed childbirth thereafter. Penny Hansen, whose mother Hedwig Hronesh Harkness operated a home and farm in Fife Lake as a registered nurse from 1920 until 1945,⁶⁵

⁶³Mrs. Newsham, who ran a small nursing home in Borden, had two daughters who had graduated from St. Paul's hospital in Saskatoon and returned to the town to run a bigger hospital with their mother until 1942. Borden History Book Committee, Our Treasured Heritage: Borden and District, 1980, pg. 16. It was not uncommon for a practical nurse to encourage her daughters to receive formal training.

⁶⁴Muriel Jarvis, Saskatoon, 31 July, 1995.

⁶⁵Hedwig was born in 1882 in the United States and had lost her first husband in the 1918 flu epidemic. Fife Lake History Book Committee, Gathering of Memories, 1981, pg. 183.

recalls her role in the birthing procedure and how that actually instilled a sense of fear about her own deliveries in the future:

That's why I never became a nurse. She delivered my oldest girl in 1946. I lived in Ontario and as a real scared girl having her first baby, I came home to Momma. She delivered my first girl and that was Linda. I had helped deliver babies - I could do it by myself, oh yes. Oh my I didn't like that at all. I did only what I absolutely was told to do. I was standing by and knew what to expect, what a gory looking mess. It was quite a thing. Lots of times mom would have to have a rest or something and if the mother wasn't nursing the baby, well I'd have to keep the baby and don't wake mom. I mean I did all these things, nothing to it, it just seemed to be an everyday occurrence. Lots of times I used to have to get behind, if there wasn't anybody there and she didn't have anything [chloroform], I'd generally hold the lady's hands like this [up beside her ears]. You may not think that this helps but it's for pulling on. I'd help from behind and stayed away from it as much as I possibly could because I really didn't want to be in on it. It was a scare and that's when it was a natural birth. [But] my Dad said my half sister would not help her. I guess she just liked to play the piano.⁶⁶

While the largest responsibility was placed on the eldest girl in the family, all members of the unit, especially where the mother had been widowed, were expected to contribute to the running of the home, both as a place of residence and as a business:

⁶⁶Penny Hansen, interview by the author, tape recording, Red Deer, AB., 29 August 1995. Mrs. Hansen's mother Hedwig ran the Fife Lake maternity home from before Penny was born to several years after she had moved away and married. Penny literally grew up in the maternity home environment and was one of the very few children to be born to a woman currently running a maternity home.

We all had our chores to do, we all helped. The boys would carry the babies around, lullaby them, I mean we were all in it. But basically mother did all the work. And we never took turns at night helping her though we certainly helped with the babies during the day time. I remember many (evenings) sitting with a baby on my lap, trying to do homework and keep my eyes open.⁶⁷

Free time was a rarity for the matrons of a nursing home. A great deal of time was spent making the home safe and comfortable for the patients and exhaustion was dealt with on a daily basis:

Gramma never really slept, if she did it was on the chesterfield, she was just a little bit of a woman, but she just didn't sleep. She didn't have a room that she could say this was her bedroom.⁶⁸

Another maternity home matron lamented her lack of sleep in a "ordinary three-bedroom house that sometimes had ten patients - counting the babies":

I never slept. I didn't have time for sleep. If I'd stand beside the basket holding the bottle and feeding the baby, I'd almost fall asleep in my tracks, I was so tired. One baby would waken the others; they'd all start crying and then you'd have a real choir.⁶⁹

The nature of maternity work itself lead to exhaustion. Although the matron of the home would have a good idea about when to expect a certain woman, at times several women would

⁶⁷Muriel Jarvis, Saskatoon, 31 July 1995. Muriel was the eldest of five children and at the time of her father's death had not yet started school. Her mother was a widow at age 26 and thus was much younger than most women who operated maternity homes.

⁶⁸Hazeldene Evans, Carlyle, 23 July 1995.

⁶⁹Minnie Johnston, quoted at length in Henri Chatenay, The Country Doctors (Mattrix Press: Red Deer, Alberta, 1980), pg. 256-257.

enter the home to deliver in rapid succession. For example, Mabel Hultien of Midale reported the following birth schedule in 1943. Keep in mind that each woman would stay for at least ten days:

February 8	9:30 AM	Oliver
February 10	1:05 AM	Sharif
February 12	3:45 AM	McNamie
February 12	6:00 AM	Ruckaber
February 14	8:00 PM	Peterson
February 17	3:30 AM	Manley ⁷⁰

While this number of patients in the home at one time was relatively rare, even half that number of patients and babies would have kept even a very efficient woman busy. Things at times were so hectic that the operation must have bordered on chaos.⁷¹ Hobbies were rare for such a busy woman but Lydia Evans found time for reading:

Now she was a lover of murder-mysteries and she introduced me to them. I always used to laugh and think I could just see her in the delivery room with some poor women in the throes of giving birth to this child, moaning and groaning and Grandma giving her a swat and saying be quiet, I'm at a good point in the book!⁷²

Other women went on short visits to friends or to bigger

⁷⁰This list was found in one of Mabel Hultien's autograph books which she asked each patient to sign before they took their baby home. Access to these books is courtesy of Edna Andersen, Mrs. Hultien's daughter, of Estevan.

⁷¹Ibid. Violet Oliver writes of Hultien's home "here's hoping you at least have a bed to sleep in from now on. Oh what a houseful!" Mrs. Oliver had a girl in February of 1944, the first of that year and was in the home for four weeks.

⁷²Hazeldene Evans, Carlyle, 23 July 1995.

cities for annual events.⁷³ Others took up the arts as did Lottie Meek of Abernethy, who in later years began painting,⁷⁴ and Margaret Dalziel of Oxbow, who belonged to the local drama club in the 1930s and "was in all plays presented to the public."⁷⁵

In addition to the help given by the children of the family, maternity home matrons also received assistance from neighbourly women in the area, usually those living close by that could be called at short notice to lend a hand. Often young girls would do part-time work, either on a volunteer basis or for a small wage, at a nursing home as a community building gesture initiated by the girl's mother.⁷⁶ These

⁷³The Shaunavon Standard reported on August 4, 1932 that "Mrs. D.C. MacKenzie and son Gordon are at the Regina Fair this week" and on November 23, 1933, "Mrs. Carl Dahl, Admiral, is the guest of Mrs. Gilbert Morstad, Grassy Creek, for a week or two". Both Mrs. MacKenzie and Mrs. Dahl ran thriving maternity homes.

⁷⁴One subject of Miss Meek's perhaps sheds some light on her view of her career as a maternity home owner. "She enjoyed painting pictures of early events as they were told to her. We have in the family, a painting showing her mother standing in the door of the shack holding a lighted lamp, while she watched Samuel escorting Mrs. W.B. Dickin across the moonlit, sparkling snow. She was coming to act as midwife. What brave women these early pioneers were! They shared each others joys and sorrows and offered help in every diaster. They were truly 'the salt of the earth.'" Olive Dunnington-Meek (Abernethy Heritage Association), Dance on the Bridge: A History of Abernethy and Area, 1983, pg. 482.

⁷⁵Oxbow-Glen Ewen History Book Committee, Furrow to the Future: Oxbow and Glen Ewen, Volumes 1 and 2, 1984, pg. 495. By all reports, Mrs. Dalziel, whose nursing home was open during the 1930s, was a "very good actress."

⁷⁶Women in the area lent a hand in other ways as well, in fact assisting a woman in opening the home in the first place. Nurse Jean Scott, for example, bought a home and "a group of her friends held a district shower from which she got sheets, blankets, dishes, etc. all very much appreciated and needed by Jean." For a woman who would never marry, the idea of a women-initiated drive for supplies must have been very similar to a wedding shower and quite similar in fact to a baby shower. Cupar Historical Committee, Cupar and District: Taking Root...And Growing, 1981, pg. 376.

girls mainly worked after school and on weekends, preparing meals, doing laundry, washing dishes, general cleaning up, and on occasion were asked to feed a baby or give them a bath.⁷⁷

Some maternity homes did take on trained nurses and generally were more likely to do so if the matron was a formally trained nurse herself. For example, Miss Bessy Cook, a graduate of St. Paul's Hospital in Saskatoon assisted Mrs. Ross in Shaunavon, who was a practical nurse with many years experience.⁷⁸ There is some evidence that hospital-trained nurses were reluctant to relocate to small rural centers. Kathryn McPherson, for example, has argued that "nurses often found rural health care markets inhospitable to single working women and in response, nurses often justified their presence there in terms of missionary service to the marginal populations of rural society."⁷⁹ Predictably, the 'inhospitable' climate was a result of two factors that nurses originating in rural settings could have anticipated. For one, there is a distinct tension between town and country elements in a rural setting. Going to the big city for

⁷⁷Dorothy Brown, for example, worked at Lydia Evans' nursing home in Carlyle from the time she was twelve to about eighteen. She made about \$4 a week and eventually \$5 per week, at which point she thought she 'was rich.' She made a small wage from her mother's friend and was inspired to take nurses training in Manitoba. She unfortunately contracted tuberculosis not long after entering school and was forced to return home. Dorothy Brown, interview by the author, tape recording, Carlyle, 4 August 1995.

⁷⁸The Shaunavon Standard, August 18, 1932.

⁷⁹Kathryn McPherson, "'The Country is a Stern Nurse': Rural Women, Urban Hospitals and the Creation of a Western Canadian Nursing Work Force, 1920-1940" Prairie Forum Volume 20, No. 2 (Fall 1995): 175.

nurses' training would give these young women "the opportunity to put on airs in front of their country cousins"⁸⁰ and this 'cultural gap' would definitely generate some hostility. The perceived pretentious attitude of graduate nurses had some base in fact as they were known to seldom take 'country cases' because of the sheer work load required.⁸¹ Secondly, and especially in the Depression years when hospitals were not hiring and private duty work had fallen off, small rural communities often had a local nurse who had been doing the job quite adequately. The problem then was not a lack of nurses but a lack of money with which to pay them. Nurses may in fact have been seen as competition to the nursing homes.

The Depression obviously meant that a certain number of graduate nurses would make themselves available to work in nursing homes. In areas where the Rural Municipality assisted its residents in paying medical bills and in cases where the provincial government would pay a portion of the nurse's wages (which they did on occasion), it only made sense to 'hire a girl.' These women most often lived right in the home, received room and board and were on-call at all times. It is probable that some strains developed in the working relationship between matron and nurse, especially if the

⁸⁰Gerald Friesen, The Canadian Prairies, pg. 326. Friesen attributes the unstable relations between town and country elements as a residual of the early relations of merchant and consumer, in which the consumer often came up short.

⁸¹McPherson states as well that "many Canadian nurses in the interwar years would not accept 'country cases'." "'The Country is A Stern Nurse'," pg. 190.

matron was practically, rather than formally trained. The science of medicine had increased in complexity in the 1920s, 30s and 40s by "developing new treatments, surgical methods and...new drugs."⁸² Influenced in technique by doctors only, many of whom had been out of medical school for decades, matrons perhaps felt that they had failed to keep pace with the changing, modernizing and increasingly scientific aspects of their work. The presence of a graduate nurse brought this 'failure' to the fore.⁸³ In addition, formally trained nurses were educated to conduct a different sort of relationship with their supervising physician, to adopt a distant assisting role which would never question the physician's supremacy. Working with a hospital-trained nurse may have caused some friction between the matron and the doctor. No doubt his demeanour would have to fluctuate between one of respectful partnership and that of order-giver as a matter of professional privilege depending on whom he was dealing with.

Maternity home matrons also had contact with graduate nurses from the Department of Health, which in later years sent nurses out to inspect nursing homes that had applied for

⁸²Marquerite E. Robinson, The Saskatchewan Registered Nurses Association: The First Fifty Years (self-published, 1967), pg. 123.

⁸³Veronica Strong-Boag's concept of professionalism constraining feminism in "Canada's Women Doctors: Feminism Constrained" in A Not Unreasonable Claim Linda Kealey, ed. (Toronto: The Women's Press, 1979) and referred to in Dianne Dodd's article "Helen MacMurchy: Popular Midwifery and Maternity Services for the Canadian Pioneer Women" in Caring and Curing: Historical Perspectives on Women and Healing in Canada Dianne Dodd and Deborah Gorham, eds. (Ottawa: University of Ottawa Press, 1994), pg. 154 is very applicable here in describing the relationship between nurse and matron.

a license or wished to have their license renewed.⁸⁴ In the immediate post-war years, public health nurses were instructed to determine the exact qualifications of the matron, examine all records and "make enquiry regarding other nursing homes which may be operating in order that there will be no possibility of overlooking any."⁸⁵ That these nurses, in a position of authority, had the power to recommend that a license be revoked or awarded caused further distance between private and public nurses. There is, however, some evidence that these nurses recognized the contribution made by the matrons in rural areas:

As there is no hospital in the district, I find this home a convenience for maternity cases [though the matron] speaks only French.⁸⁶

Still though, they did judge matrons by their formally-gained, modern standards and a hint of condescension is evident, despite the fact that most homes had been operating for decades:

⁸⁴See Appendix 6 for two examples of the licenses issued to maternity homes by the Department of Public Health.

⁸⁵Memorandum from the Director of Nursing Services to Public Health Nurses of July 25, 1946. GS 64, PH 5, File 42, Department of Public Health-Nursing Division, SAB. These demands on maternity home matrons perhaps caused some tension between Public Health Nurse and matron by violating the privacy of the matron and possibly insulting her intelligence. On the other hand, the Public Health Nurse could supply advice and literature to the matron and there may have been some degree of professional courtesy involved.

⁸⁶Public Health Nurse L.F. Sawyer inspection report of Mrs. Sarrazin of Spiritwood on October 29, 1943. "Division of Public Health Nursing Private Hospitals and Nursing Homes Inspection Report" GS 64, PH 5, File 42, Department of Public Health-Nursing Division, SAB. It is not known if these two women actually communicated and bridged the language gap during the inspection.

Mrs. Smallcombe is doing such good works. I suggested to her that she make an effort to get her Reg. N. She states she has grade nine secured in the old country [England]. I suggested that she have this standing rated here to see what she could do.⁸⁷

A great proportion of graduate nurses, enjoying more mobility than nursing home matrons, vacated their jobs in rural communities at the beginning of World War II. In the fall of 1939, "the Commission on Enrolment of Nurses for War and Emergency was recognized by the Department of Defense and everyone agreed that special demands would be made on the nursing profession."⁸⁸ Fewer nurses were available for hire both in nursing homes and as private duty nurses, which meant that those who normally would have hired a nurse to come to their home now had to come to a nursing home or hospital. Aside from the exchange of technical information, the migration of formally trained nurses into the larger urban centers and the war department benefited matrons as it allowed them to enjoy steady business with little competition until the war was over.

The relationship between the local doctor⁸⁹ and the

⁸⁷Public Health Nurse E.J. Word in her inspection of Mrs. Smallcombe of Shellbrook on October 9, 1943. Ibid. Mrs. Smallcombe had two years of formal training in Saskatoon, administered all anaesthetics herself and handled over 80 maternity cases in 1943.

⁸⁸Marquerite E. Robinson, The First Fifty Years, pg. 74-75.

⁸⁹For the purposes of this paper, I have assumed that doctors in all cases were male. This, of course, is not always true as there were on occasion female doctors practicing in southern Saskatchewan. The relationship between female doctors and nursing home matrons would be interesting to research but there is a definite lack of information about female doctors in this era, partly because they did not stay in one area

maternity home operator invariably was one of partnership tempered by real societal power differences in an age when full-facility hospitals were few and far between. While travelling mid-wives (who visited farms in outlying areas and were often paid directly by their patients) were a threat to a doctor's income because they charged much less and it was difficult to monitor their activities, those centralized in their own homes came under the doctors' realm of power and observation. Often it was at the doctor's instigation then that a woman opened her home for medical services. Lydia Evans remembers how it happened that she got started:

In a few days Dr. Stapleford called on me. Said he heard I was a nurse and he would be very glad of help. I told him I had two young boys and could not leave them. He said we would get someone to look after them, which we did. I told Dr. I had brought nothing with me (from England) to show I had training. He said never mind. I will judge you by your work. I presume I was O.K. He gave me lots of work.⁹⁰

Because the success of such a home ensured that the owner would continue to operate the business and not go out to people's homes, local doctors would almost always arrange for

for very long. Dr. (Miss) M.E. Allan, for example, combined teaching and medicine in Alameda but "this was just at the end of the old century and lady doctors or any woman in a profession had a real struggle, not only with the elements, but with prejudice in what was considered a man's world". She had left by 1906. Alameda and District Historical Society, From Dream to Reality, Alameda, 1982, pg. 21. For an in-depth look at female doctors in Saskatchewan, see Phyllis L. Steele, The Woman Doctor Of Balcarres (Hamilton, Ontario: Pathway Publications, 1984) and Ruth Matheson Buck, The Doctor Rode Side-Saddle (Toronto: McClelland and Stewart, 1974).

⁹⁰Prairie Trails to Blacktop: Carlyle and District, pg. 657.

their patients to go to the local maternity home to deliver, providing they were on good terms with the matron. Some maternity home owners actually credit the local doctor with the idea that allowed them to support their families. Mrs. Esther Jarvis of Kenaston, for example, stated that "Dr. Clarke (had) encouraged (her) to take patients into (her) home, so with his help (she) set up a nursing home."⁹¹ While immediate accessibility to the patient was preferable for a doctor, he also had some control over the maternity home matron. For the physician, this eased, but by no means erased, the advantage that a woman who had provided services for several years and was a community member enjoyed over a doctor who, in most cases, was a relatively recent addition to the community.

In some cases, the departure of the local doctor also meant the end to a nursing home. Practicing medicine as a team left a

Figure 2 Dr. Porter and Annie Bradley on the porch of the Cadillac Nursing Home in the mid-1940s.

⁹¹Kenaston History Committee, Kith'n Kin: The History of Kenaston and District, 1980, pg. 144.

matron feeling perhaps unequipped to deal with cases on her own. Doctors, like graduate nurses, had more mobility than matrons and could at any time move on to a more profitable practice elsewhere. If the doctor had been instrumental in encouraging a woman to set up a nursing home, a matron would see herself as having no choice but to close down after his parting. Lottie Meek of Abernethy was one such matron whose business depended on the local doctor. "When finally there was no resident doctor she was forced to sell the building and move to Regina, where she operated a rooming house for many years."⁹² This battle to keep a regular doctor and thereby stabilize the business meant that matrons would have supported the Municipal Doctor scheme that guaranteed a local doctor a salary from the Rural Municipality.

There is some question as to how regularly the matrons called in the local doctor in maternity and emergency cases. It is clear that in the late 1920s and early 1930s, if a doctor was available and the case appeared problematic, a matron would at least try to get in touch with the doctor. Whether they needed another pair of hands or thought they could not do it by themselves or felt obligated to call the doctor is not known.⁹³ Without a doubt, by this time, Helen

⁹²Dance on the Bridge, pg. 484.

⁹³A common sentiment was expressed by Lola Boyd from Lafleche who stated that during her nursing career, "(she) brought a number of children into the world unassisted by a doctor, not because (she) wanted to, but because (she) was caught...and I'm proud to say I never in my nursing career had a case of infection in childbirth or operation". Woodriver Historical Society, Golden Memories of the Wood River Pioneers, 1980, pg.

MacMurchy's campaign for "physician-attended deliveries" had grown in popularity and most health care consumers and caregivers were aware, if not convinced, of the perceived danger of giving birth without a medical doctor.⁹⁴ Government officials had successfully created the myth that everything associated with the town was good and everything in rural settings was backward and related this to the issue of childbirth. As early as 1914, the Department of Health read this dichotomy into the statistics:

(Childbirth) occasioned 112 deaths this year. Of these, 28 were in cities and towns while 84 were in villages and R.M.s, the latter being 75% of the deaths from this cause. It is quite evident, therefore, that a large proportion of these deaths occurred through the lack of skilled physicians being in attendance, another instance as proof that life might be conserved through proper medical methods.⁹⁵

What this commentator fails to mention is that the actual population numbers are higher in rural areas (villages and R.M.s) than in urban areas (cities and towns). As Saskatchewan was very rural in nature, a larger population in villages and R.M.s would obviously mean that the number of maternal deaths there would be higher there. A more useful

29. A doctor might be out on a call, away at a meeting or otherwise unavailable. A matron then would have no choice but to conduct the delivery on her own.

⁹⁴Dianne Dodd, "Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women," pg. 149. Dodd details MacMurchy's attempts to reconcile her disapproval of midwives with the lack of medical care in most 'outpost' regions.

⁹⁵Annual Report 1914, Department of Health, pg. 107.

statistic, maternal deaths as a percentage of births in each area, is not forthcoming.

Despite the official national goal of physician attendance for childbirth, some matrons reasoned that they were better off on their own, without the doctor. Annie Rutherford of Carlyle, for example, told a friend that "she had never lost a baby when she was alone. It was after the railway came in and she had a medical doctor to help her that the babies started dying."⁹⁶ As the years went by, the doctor was almost always called, usually right at the last possible moment. Throughout the first forty years after the turn of the century, physician-assisted births always had a higher percentage of infant deaths, not including stillbirths, than those assisted by a nurse or neither a doctor nor nurse. This explains why the numbers of births attended by a doctor increased (see Appendix 7) in the province while the number of hospitals remained virtually the same during the 1930s; there was a growing tendency for matrons to make use of available doctors in their area. Births attended by nurses (which may or may not include maternity home matrons) were the only category to fluctuate while physician attendance increased and the percentage of births assisted by neither physician or nurse (and may include nursing homes) decreased at a very gradual rate. In the time period this study focuses on, the 1930s and 1940s, doctors were virtually always present but it was left

⁹⁶Prairie Trails to Blacktop: Carlyle and District, 1982, pg. 918.

to the discretion of the matron when and if she contacted them.

That doctors and maternity home operators competed on a fairly equal level in terms of skills is clear, especially between relatively young doctors and women with decades of experience in delivering health care.⁹⁷ These women often performed medical procedures other than childbirth assistance.⁹⁸ Amputations, tonsil and adenoid removal, stitching and appendectomies were just some of the procedures that these practical nurses could and did carry out on their own. Reports on these nursing homes from the Department of Public Health declare what type of cases were cared for from statements from the matron. They range from "maternity only" to "maternity, surgical, medical," "maternity, medical, tonsillectomies and circumcision" and "all ailments except tuberculosis." Others are more specific as to what treatments they would conduct. Some would do "minor operations" that would include "emergency work" and "kidney stone cases".

⁹⁷While years of experience may have acted as a leveller in terms of who was most qualified when the doctor had been formally trained in and graduated from medical school, at times the debates on this issue were not necessary. There is some evidence to suggest that several doctors, up until the 1930s, were not fully qualified by the College of Physicians and Surgeons. So desperate was the need for medical attendants that the provincial government passed special bills in 1908 and 1912 that allowed the men to practice medicine without being registered with the college. Joan Feather and Vincent L. Matthews, "Early Medical Care in Saskatchewan", Saskatchewan History Volume 37, No. 2 (Spring 1984): 49-50. These practical doctors were not subject to the same sort of official scrutiny that practical nurses were.

⁹⁸See Appendix 8 for an example of the many medical procedures carried out in Nurse Scott's maternity home in Cupar.

Still others offered "tonsil work" and "circumcisions."⁹⁹ The majority state that maternity work was all they did but their further records show that in fact other procedures were offered on a demand basis. Communicable disease was an obvious exception. Maternity homes were overwhelmingly opposed to admitting anyone with a contagious condition. While in every case those operating homes and their staff members had been vaccinated against typhoid fever and diphtheria, there was always the risk that a sick patient would pass the disease on to other patients. In small houses with only semi-private rooms to offer their patients, isolation was not possible. Because of the small number of communicable diseases in this era, beds in disease-specialized hospitals like the Prince Albert sanitorium were always available.¹⁰⁰

While some women specified their services as "maternity only," a good portion of women were willing, or perhaps had no choice, in taking other cases. For example, in a 1943 list of government-acknowledged nursing homes, 42.05% claimed

⁹⁹All from "Report of Private Hospital or Nursing Home" GS 64, PH 5, Files 40 and 41, Department of Public Health-Nursing Division, SAB.

¹⁰⁰One exception here is Mrs. E.M. Howell, a class of 1917 graduate nurse from the Royal Alexandra Hospital in Edmonton, Alberta, who in 1933 admitted one unspecified case of communicable disease. Her maternity home in Maidstone had room for five adults and 2 children and employed three other staff members. Given these resources, she was able to isolate the case. As required, Mrs. Howell alerted the Medical Health Officer who then informed the Department of Health in Regina. Information regarding the vaccination history of all working in a given maternity home was required on all government forms. "Report of Private Hospital or Nursing Home for Year 1933" GS 64, PH 5, File 40, Department of Public Health-Nursing Division, SAB.

obstetrical cases only, while 35.23% admitted medical, surgical and obstetrical cases.¹⁰¹ Taken in the context of the increasing pressure on the practitioners to hold recognized degrees in nursing in this era, increasing numbers of surgeries in nursing homes speak to their overall effectiveness in providing safe health care. The preference for certain types of cases no doubt was affected to some degree by the educational background of the matron, with practical nurses being less likely to admit surgical cases on an on-going basis, for example. Mrs. Isabel Hertzog-Lake of Turtleford, a graduate of the Montreal General Hospital and widowed at forty years of age in 1920, conducted almost twice the number of surgeries as maternity cases while admitting medical, surgical and obstetric cases.¹⁰² Despite the matron's preference, annual reports of nursing home cases conclude that whatever mishap or condition was referred to the maternity home in the early years was admitted almost without hesitation. A Preeceville maternity home run by Mrs. H.S. Allen, a class of 1928 graduate nurse of Regina General

¹⁰¹Ibid. Out of a total of 88 nursing homes, 37 were open for maternity cases only and 31 were open for medical, surgical and obstetrics. While this made up the bulk of the business, 17 other nursing homes admitted only medical and obstetrical cases and 3 admitted only medical cases.

¹⁰²Ibid. (Mrs. I Hertzog-Lake, 1934) and "Division of Public Health Private Hospitals and Nursing Homes Inspection Reports (Mrs. I Hertzog-Lake, February 12, 1939)" GS 64 PH 5, File 40, Department of Public Health-Nursing Division, SAB. In 1934, Hertzog-Lake admitted 23 maternity cases and 48 surgical operations. The surgeries included 37 assorted abdominal operations, 1 uterine curettage, 1 amputation and 7 tonsillectomies. Her success in this field shows as her work load increased over the years. In 1939, she handled 79 surgeries and lost only five patients. It is unclear how often a doctor was in attendance.

Hospital, reported the following caseload for 1938:

- 22 abdominal surgeries
- 1 gynaecological
- 7 uterine curettages
- 2 amputations
- 8 thyroidectomies
- 6 abscesses
- 14 tonsillectomies
- 2 circumcisions
- 5 accidents
- 1 lipoma
- 1 tooth extractions
- 2 removals of ingrown toenails
- 27 maternity cases

Mrs. Allen had another permanent graduate nurse to assist her and others whom she called in when necessary while three "medical men" brought cases to her home from the surrounding areas. Other matrons likely expected a variety of work. While being quizzed by Department of Health forms, Mrs. E. McAllister of Shellbrook, for example, expressed the inevitability of handling surgeries in her claim that she was confident only with maternity cases but had a reasonably appropriate area for emergency surgeries. Luckily, "no operation has been necessary so far here."¹⁰³

The similarities of the skills of maternity matrons and the doctors was readily apparent to those who had experience of both:

She did things just like a doctor. I've seen fellas come in from playing a game of hockey had their heads split wide open, she'd sew

¹⁰³Mrs. McAllister had, in 1934, twenty years of experience in maternity cases and had operated a home in Wilkie around 1924 before opening in Shellbrook in 1928. "Report of Private Hospital or Nursing Home for the Year 1934 (Mrs. E McAllister, Shellbrook)", GS 64, PH 5, File 40, SAB.

them all up, she could do anything but there was a doctor around. Nursing of any kind...well my dad was a veterinarian and they used to say it was quite a pair.¹⁰⁴

Long term care and convalescence, as well as emergency work, was also offered:

Mother did other nursing besides maternity. When a [community member] was dying and mother would be there in the house, just going about in her quiet way, sort of keeping everybody together and she had some cancer patients and sometimes there were bad accidents that were brought there to be stabilized and then brought up to Saskatoon.¹⁰⁵

Strangely, while maternity homes would accept extended care of the aged and infirm, almost no deaths from old age were reported in the 1930s and early 1940s in such homes. Reports of deaths occurring in maternity homes do, however, give a glimpse at what medical conditions homes in that era were unable to address. While surprisingly few deaths occurred overall, less than .05% of patients in most homes, the reported cause of death was usually outside the control of either doctor or matron given the technological standard of the day. Fractured skulls, ruptured appendixes, hyperstatic pneumonia, paralysis, acute/chronic endocarditis, cardiac failures and carcinomas of the stomach are just a few examples of fatal conditions that maternity home matrons and a local doctor could neither treat nor felt could be eased by sending

104Penny Hansen, Red Deer, AB., 29 August 1995.

105Muriel Jarvis, Saskatoon, 31 July 1995.

the patient to a city hospital miles away.¹⁰⁶

Anesthetic was used surprisingly often in prairie maternity homes¹⁰⁷ but was administered differently than in most hospitals in later years. Maternity homes gave liquid chloroform on a rag over the nose and mouth or ether while "spinal anesthetic was the anesthetic of choice" in hospitals.¹⁰⁸ While most surgeries were conducted while the patient was under a general anesthetic, a good proportion of maternity cases were given the drug as well. Several maternity homes reported that the number of maternity cases correlated exactly with the number of general anaesthetics given. Again, graduate nurses were more likely than practical nurses to give maternity patients drugs in childbirth. That some drugs had been given to women delivering in this era was obvious in exploring in detail their childbirth experiences. Many stated they remembered going into the latter stages of

¹⁰⁶Certain cases made the skill and training of both matron and doctor seem irrelevant. Mrs. Mary Linstead, for example, was unable to help a man who had been "hit by the C.P.R. train at Daphney." While he was brought to Mrs. Linstead's in the hopes that she might be able to administer some treatment, "he never regained consciousness [and] lived nearly three hours (March 15, 1939)." All information from "Report of Private Hospital or Nursing Home(1933-1943)", GS 64, PH 5, File 40 and 41, Department of Public Health-Nursing Division, SAB.

¹⁰⁷Chloroform was used much earlier on the prairies than one would suspect. As early as 1907, a prominent doctor stated "we gave chloroform altogether on maternity work and never had any trouble with it. Chloroform appeared safe when a person was in pain". W.A. Bigelow, Forceps, Fin and Feather: The Memoirs of Dr. W.A. Bigelow (Altona, Manitoba: D.W. Friesen and Sons Limited, 1969), pg. 57.

¹⁰⁸Dr. White at the Arcola hospital stated this was so "because the doctor could do the 'spinal', then rescrub and do the surgery assisted by one nurse". Arcola-Kisbey History Book Committee, Arcola-Kisbey Golden Heritage: Mountain Hills to Prairie Flats, 1987, pg. 182.

labour and the next event they remember is holding their newborn hours later. Lynn Brady of Carlyle says of her mother-in-law "she doesn't clearly remember any of the births of her three children which makes me wonder if some sort of drug was used."¹⁰⁹ The drug seems to have been given largely because maternity matrons knew what pain childbirth could cause and because they had the ability to ease the pain, they did so very often. Edna Anderson's mother, for example, "didn't want (her) to remember a thing. She conked (her) right out and (she) didn't remember anything."¹¹⁰ Alma Miller had a very difficult birth in 1946 in Carlyle and stated "don't ask me what happened after that. All I know is that I came to and there was a little white faced baby there! And I was glad for it."¹¹¹ While anesthetic further medicalized childbirth, it was a very popular technology with mothers, matrons and doctors, despite the 'gas hangover' that almost always resulted.

Anesthetic seems to have been alternatively administered by either doctor or matron, as liquid chloroform was easier to use than a spinal injection. While some maternity home owners

¹⁰⁹Lynn Brady, personal correspondence with the author, Carlyle, 19 June 1995. Lynn Brady, her three siblings (one of whom died at birth) and her husband were all born in Lydia Evans' maternity home in Carlyle.

¹¹⁰Edna Anderson, interview by the author, tape recording, Estevan, 25 July 1995. Edna's mother Mable Hultien ran a maternity home in Midale from about 1940 to 1949, many of those years with Edna to assist her. One can assume that if a mother would give anesthetic to her own daughter, she did so for humanitarian reasons. Logically, a mother would do anything she could to save her daughter from pain.

¹¹¹Alma Miller, Carlyle, 5 August 1995.

stated that the "doctor only" administered the drug,¹¹² others were more willing to admit they sometimes took over this job as well. Martha North of Quill Lake claimed that the "doctor gives some and supervises all others" while the "doctor or nurse" was responsible at Thelma Wilson's home in Loverna. Edith Barker, a practical nurse with ten years of maternity home experience, administered all 23 anesthetics given in her home. Surprisingly, no deaths from anaesthetics in nursing homes are reported in the 1930s.¹¹³

Not all doctors felt competitive with nursing home matrons and in the true spirit of prairie cooperation, some acknowledged the huge contribution that these women had made to their community:

Oh I wanted to tell you about Dr. Frechette, the one that was in Willow Bunch. He made the statement to mom one time and like he particularly liked maternity and you see mom specialized in maternity, that was her thing, she really liked that, course she was with everything else when she was [working] in the hospital I imagine. So he made the statement, he said in all his training, he learned, see mom could turn a baby, she could anything, bring a baby into this world when maybe somebody else gave up, but he said, this Dr. Frechette, he said I learned more delivering babies together than I learned all the time I was in training, and he said in my experience so far, 'cause she had little tricks here and

¹¹²If the doctor was the only one who could give anesthetic in a maternity home, this was no doubt another reason why both matrons and patients wanted him there. They did not necessarily need or want his help in the actual delivery but wanted him there to administer the drugs that would ease the pain.

¹¹³All information from the "Report of Private Hospital or Nursing Home" GS 64, PH 5, File 40, Department of Public Health-Nursing Division, SAB.

there...¹¹⁴

For nursing home matrons who had lost their husbands or were single, the doctor no doubt at times provided male companionship on a partnership basis. Further, the doctor's relationship to the family could regularly exceed medical care alone and take on a fatherly tone. Edna Anderson remembers Dr. Mainprize's connections to both herself and her mother:

Lots of times when she went out with the doc, he'd go up and down the hills in his snowmobile, whatacallit, and she'd yell "Open the door - I've got to puke!" And he'd say "What's the matter with you?" And she'd say "it's your crazy driving!" They were great friends. The doctor took care of me when I was born and then I was with him in the nursing home and he gave me away as a bride and then he was with me when my two kids were born, just like a dad.¹¹⁵

So while the maternity home nurse and the doctor may have felt equally confident in making medical decisions and performing procedures, in a situation where both were present, the doctor alone was officially able to, even when he perhaps was behaving unprofessionally:

I think in those days, the doctor was kind of God (to the public) and they didn't question. Their (the doctor and matron) relationship was very good. But I know some later doctors, one in particular, was known to touch the bottle a little too heavy and a couple of times mother had to say here, give me that.¹¹⁶

¹¹⁴Penny Hansen, Red Deer, AB., 29 August 1995.

¹¹⁵Doctor Mainprize was the doctor in the Midale area for over forty years. Edna Anderson, Estevan, 25 July 1995.

¹¹⁶Muriel Jarvis, Saskatoon, 31 July 1995.

A matron, on the other hand, was not often allowed such an expression of confidence and power in front of the public. In the case of negligent action, the maternity home owner would have to call attention to her community ties in order to supersede the doctor's authority. Nora Pollard Singleton tells a story of diagnoses conflict between doctor and maternity home nurse that ended tragically:

Oh yes when my younger brother took ill Nurse came to Mothers assistance & Dr. Sample. I am afraid the Dr was a bit (well I have to watch what I say about this) The Dr was ordering hot plates to be put on Jackie (my brother) & it turned out to be appendix instead of kidney trouble. Finally Nurse said I think it is appendix Mrs. Pollard, so against Drs will my father had Jackie taken to Arcola hospital (9 miles) by train and on arrival at Arcola train station Jackie said Daddy you can take me back home, ask the train man if he will go back. Alas his appendix had broken. He was just coming 7 but he didn't survive & what a tragedy at our house. He had 5 sisters older & one brother older, then himself and a 3 yr old sister, so there was a lot of crying. Jackie was born in 1922 & died in 1930. Everyone around loved Jackie, he was such a good brother. I know I was lost for a long long time.¹¹⁷

Contact with 'professional medicine' other than doctors and trained nurses did occur in nursing homes. For example, a representative of the Canadian Red Cross often gave instruction in first aid at the Carlyle Nursing Home.¹¹⁸ Mrs. Dyon in Antler also allowed travelling dentists and

¹¹⁷Nora Singleton, personal correspondence with the author, Kisbey, 8 October 1995.

¹¹⁸The Carlyle Observer, July 21, 1949.

optometrists to set up their equipment in her parlour during the 1920s and hold open clinics.¹¹⁹ This further shows the commitment of nursing homes to community health in general.

In later years, when legislative control over the operation of maternity homes was increased, doctors, not surprisingly, were given more control over the fate of their local maternity home.¹²⁰ This trend first appeared in the licensing applications, beginning in the late 1920s, for maternity homes, filled out by the matron.¹²¹ While the first item of information, "Name of person in charge", is always the matron's name and she filled out the bulk of the form, doctors are usually cited as references at the end of the questionnaire. At times, the local doctor has written on the form that he "assumes responsibility for [the hospital]

¹¹⁹Mrs. Dyon also allowed piano tuners and the like to stop over at her house. Antler and District History Committee, Footprints in the Sands of Time, 1983, pg. 107.

¹²⁰It is clear in the majority of correspondence from the maternity home matrons to the Department of Health that the matrons' focus of authority is firmly on the local doctor and there is a distinct unease on the part of the matrons in dealing with the provincial government. An example comes from Mrs. Lacharite from St. Brioux. She writes "it is because these women were unable to go to the hospital and it was too far for the doctor to go in the country and no help. As I am not a graduated nurse just a helping lady as the Doctor Bachand knows me, he has chosen me to work with him." It would seem that Mrs. Lacharite believed the doctor's need of and request for her maternity home was all the official approval she needed. Her letter has a 'willing to please' tone that seems to be attempting to placate the reader. Letter of April 1, 1944 attached to the "Division of Public Health Nursing Private Hospitals and Nursing Homes Inspection Reports (March 16, 1944)," GS 64, PH 5, File 42, "Department of Health-Public Health Nursing Division," SAB.

¹²¹These forms are headed with the title "Application Form For License To Conduct Private Hospital, Maternity Home, Rescue Home, Children's Home, Or Similar Institution, To Be Completed And Returned To Deputy Minister Of Public Health."

conduct."¹²² So while the reality was that the doctor and nurse worked in coordination with one another, to community outsiders it seemed that the doctor's approval and endorsement was necessary in order to establish the business.

While nursing homes were run as a business intended to support a family, their position as a community service run by women put certain limitations on how the business was made visible to the community. For example, unlike physicians, dentists, optometrists and surgeons, who all advertised in local newspapers, very few ads for maternity homes can be found compared with how many were operating.¹²³ The Maple Creek News, a paper from the southeast corner of the province,

¹²²Mrs. Elsie Townsend, Balcarres, SK., "Application Form for License," GS 64, PH 5, File 39, Department of Public Health-Nursing Division, SAB. Dr. R.E. Brown has written "The hospital will be in charge of Dr. Ronald E. Brown, who assumes responsibility for its conduct," which I understand to mean that the home would operate under his guidance. It is clear that this doctor, for a variety of reasons, no doubt, wanted this maternity home to be granted a license. He has also written the names of two other doctor's as references, one from Regina and one from Indian Head.

¹²³Only two such ads, both in the same paper, were found in archival searches of several newspapers in the research area during the 1920s, 30s and 40s. The Maple Creek News ran an ad on January 18, 1923 in the Local and General column that read:

Maternity Cases looked after at my home in Piapot -
Apply to Mrs. Catherine Stewart, Piapot, Saskatchewan.
The ad reappeared on January 25, 1923 and was not published again. Because ads were so rare, I would argue that this home maybe was advertising to attract unwed mothers or was providing abortions. As well, Piapot is roughly 30 kilometres from Maple Creek and thus was far enough away to conduct either of the above without prohibitive transportation costs and to be out of the view of one's immediate community. Seven years later The Maple Creek News of June 12, 1930 (Vol. XXVII, no. 42, pg. 2) carried this ad:

Have comfortable rooms for patients convalescing from confinement or other causes. For rates apply to Mrs. O.A. Covey, Pacific Avenue, Maple Creek.
Maple Creek had a small general hospital funded by the Red Cross but it suffered serious financial difficulties. Convalescing elsewhere would certainly be cheaper than in this hospital.

contains advertisements as early as 1922 for health care delivers of all types excluding nursing homes.

The charging and collecting of fees generated by a maternity home was also unlike other businesses of the time. While Angela Boyd has argued that maternity homes were established as short-term projects in the "spirit of community service" and that "any attempt to make such services permanent was usually thwarted by the cost of the operation (because) income was derived solely from payment by patients who often had very meagre cash resources,"¹²⁴ it is obvious that many homes operated for extended periods of time with closing due to the influence of provincial health care legislation and the age of the matrons rather than economics. That is not to say that the business end of the operation was not problematic. Throughout the 1930s and early 1940s, the price for a day of care in a private nursing home did not change

¹²⁴Angela Boyd, Pioneer Health: An Analysis of a Survey of the Health of Saskatchewan Residents: 1878-1914 (Regina: Saskatchewan Department of Public Health, 1971), pg. 2. The specific era in which service was available is important when determining whether or not these women expected to get paid. Just before and after the turn of the century, it appears that women who acted as midwives, not maternity home operators, did not often get paid. This perhaps is another reason why women largely gave up on going to the patients and let the patients come to them. Ethnic background played a role in the early years in Foam Lake where Mrs. Shychoski, a Polish trained midwife, "never charged the people for her work but did receive some money as it was a custom to throw silver into the water in which the baby was being bathed," in the hopes that the child would be prosperous. Whomever gave the baby its first bath was entitled to the money. When approached by the Department of Health in 1918 about signing a certificate giving her permission to charge for her work, Mrs. Shychoski refused. Foam Lake History Society, They Came From Many Lands: A History of Foam Lake and Area, 1985, pg. 54.

significantly.¹²⁵ Only after hospitalization was instituted did prices see a slight increase. Prices in the pre-1944 years, on average, ran from about \$2.50 to \$3.00 per day for a semi-private room, with private rooms running anywhere from \$2.50 to \$5 per day. Operating rooms, where available, were subject to a flat charge in most cases of \$10.¹²⁶ Compared with a doctor's rate of approximately \$2 for an office call and \$5 for a house call in the same period,¹²⁷ and around \$2 per day in a hospital,¹²⁸ it was more efficient to come to a maternity home and get cared for there, not too far from family and near an experienced woman who was well-known in the community. In the years of a straight fee for service, a

¹²⁵Lydia Evans for example charged \$2.50 per day in 1934 and was still at that rate in 1939. "Application Form for License", GS 64, PH 5, File 40, Department of Public Health-Nursing Division, SAB.

¹²⁶There are some inexplicable variations to these average prices. Some women charged extra for the 'case room', so the actual day of delivery was more expensive than the recuperation time. Mrs. May Coubrough of Coronach stands out as the cheapest maternity home at "\$1.75 a day for maternity cases in bed, \$1/day while up", a low price for 1939. Graduate nurses tended to have more complicated payment schedules; Miss K.M. Bailey of Cutknife (Edmonton General Hospital class of 1928) charged \$5 for "case and dressings" and a flat rate for maternity up till twelve days of \$30. "Application Form for License" and "Report of Private Hospital or Nursing Home," GS 64, PH 5, File 40 and 41, Department of Public Health-Nursing Division, SAB.

¹²⁷Dr. Cameron's rates for the Arcola-Kisbey region, Arcola-Kisbey Golden Heritage, pg. 183. Both Nurse Smith in Kisbey, who operated her home from 1922-1940, and Lydia Evans' Carlyle home until 1949, charged less for medical attention separate from that of the doctor in the same immediate area. Although the hospital opened in the mid-1930s, both women had more than enough patients to support themselves. In the early 1900s, a doctor's office calls were about \$1 while house calls were \$2 and maternity cases were a flat rate of \$30; still more expensive than the early maternity homes. Balcarres History Book Committee, Furrows in Time: A History of Balcarres and District, 1987, pg. 186.

¹²⁸Phyllis L. Steele, The Woman Doctor of Balcarres, pg. 24. Steels states that this \$2 charge was "an unbelievable amount of money to people at that time", the mid-1930s.

transfer of payment from customer to care giver, the process involved less bookkeeping on the part of the matron. Unlike other services where paying for any sort of female labour might seem of less urgency, it would seem that the payment for treatment in a maternity home was of a high priority.¹²⁹

The Depression, of course, meant that many matrons were unable to collect many of the fees owed them. While people would only seek medical care when absolutely necessary, many bills in this era were never fully paid. In many cases, the town would give the matron tax concessions and the R.M. often paid some of the bills the matron was unable to collect.¹³⁰ In areas where taxpayers contributed to a health care fund, matrons would apply direct to the council for payment.¹³¹

¹²⁹Ironically, paying the doctor seems to have been less of a priority than paying the matron. During the Depression when the provincial government was supplementing the funds the R.M. had available for the doctor's salary, the attitude was "you're getting money from the government, why should I pay you?" Judith E. Totten, Saskatchewan, 1930 to 1939: Preparation for State Medicine (Unpublished paper for the Department of History, University of Regina-held by the Canadian Plains Research Center-April 1975), pg. 17.

¹³⁰The R.M. would also assist in the collection of patient dues by sometimes allowing roadwork done in the district to apply directly to a nursing home account. Qu'Appelle Historical Society, Qu'Appelle: Footprints to Progress: A History of Qu'Appelle and District, 1980, pg. 88.

¹³¹For purposes of illustration, the Shaunavon Town Council meeting declared claims made by the nursing homes, local doctor and the union hospital contribution to be under the 'public works' accounts. In April of 1932, for example, the following bills were approved for payment:

Ross Nursing Home	15.00
Dr. Boyd Story	113.00
Mackenzie Nursing Home	62.50
Union Hospital	561.50

It is impossible to know if the charges made by the maternity homes were for charges they were unable to collect but it seems likely that the residents were covered by some kind of plan and the matrons were billing the appropriate town or R.M. directly for their services. Shortly after the monthly claims were made to the town of Shaunavon, claims were made by the homes to the surrounding R.M.s whose residents came to the homes for

People found other ways to compensate for the services:

In the hard up days, they'd come in there and couldn't pay for staying there or anything but they'd bring her butter and meat and things, especially the farmers, and that's how she got paid and she really appreciated that.¹³²

Likewise, the Newshams received "the bulk of (their) pay for hospital services in chickens, oats, oat sheaves, cows, pigs, vegetables, sewing machines and a couch."¹³³ Public hospitals, whether union, religious or run by the Red Cross also accepted donations of such supplies in this era. There is some debate on whether or not matrons even expected to get paid. The women for whom the issue of "could anyone pay or not pay, was farthest from her mind"¹³⁴ truly had the community at heart but one can assume that most did hope to

care. On June 9, 1932, the R.M. of Bone Creek passed a bill of \$27.50 to the Ross home while on June 16, 1932 the R.M. of Grass Creek motioned for payment of \$50.00 to the Mackenzie home and \$175.50 to the Ross home. The monthly nature of claims to several different political bodies indicates a very sophisticated bookkeeping system would be necessary. Virtually every town council and R.M. meeting forwarded a portion of their diminishing funds toward maternity homes, meaning their payment was of high priority to the town. The Shaunavon Standard, April 7, 1932, June 9, 1932 and June 16, 1932. See Appendix 9 (courtesy of Frances Gaber, Cupar) for an example of nursing home matrons billing their R.M. for service rendered to its residents.

¹³²Dorothy Brown, Carlyle, 4 August 1995. Other useful items were given to maternity matrons in payment. Jane Mansfield, a matron in Bethune, was given a hand Singer sewing machine in payment for one case. Bethune and District Historical Society, Wagon Trails to Blacktop, 1983, pg. 268.

¹³³Borden History Book Committee, Our Treasured Heritage: Borden and District, 1980, pg. 216.

¹³⁴Footprints in the Sands of Time, pg. 876. This quote is referring to Mrs. Scott.

get paid for their services.¹³⁵

When the war was on, the nursing homes were still restricted in their operation because of rationing. With extra mouths to feed, it took special planning:

We'd be rationed, things were rationed. So we'd have each of them bring 1/2 cup of sugar or whatever they could spare in a jar and for baking, we'd take a tablespoon of sugar from each jar. Luckily for canning time, we got extra rations.¹³⁶

After the CCF election victory of 1944, there was an "injection of expertise and capital"¹³⁷ in the health care sector. The government's introduction of the Saskatchewan Health Insurance Plan (SHIP) meant matrons were able to directly bill the Department of Health for their services and while guaranteed payment added to the financial security of the household, this gradual takeover meant the homes would soon be phased out.

The maternity homes in themselves reflected the middle to lower class nature of the families that lived in them and the community they served.¹³⁸ This varied depending on location.

¹³⁵Borden historians claim that the Newshams, a mother and two daughters who ran the local home, "operated the cottage hospital as a community service, rather than a profit making venture. It was never a paying venture, but more of a service of dedication to the people of the Borden area." Our Treasured Heritage, pg. 16 and 216.

¹³⁶Edna Anderson, Estevan, 25 July 1995.

¹³⁷Aleck Ostry, "Prelude to Medicare: Institutional Change and Continuity in Saskatchewan, 1944-1962" Prairie Forum Volume 20, No. 1 (Spring 1995), pg. 95.

¹³⁸A discussion of the houses themselves is important because at times, their recognizability, construction and location was the reason the next woman who occupied the house became a maternity home matron. This happened surprisingly often. For example, Mrs. Wood, a trained nurse,

For example, Saskatoon and Regina tended to have homes that were larger and more modernly-equipped than those in small rural villages.¹³⁹ The number of available beds gives some indication of house size and thus of class. Generally, homes in larger urban centers had more space for patients than their counterparts in the country. The contrast of two representative rural and urban houses illustrates this. Mrs. Barkley in Saskatoon had room for 16 patients while Mrs. Mary Mcfadyn in Maryfield had beds for only four.¹⁴⁰ In any case, the smaller number of available beds in the average rural maternity home meant more personalized attention for each patient. In most cases, registered maternity homes in Regina and Saskatoon are still standing and inhabited while homes in smaller towns have long since been demolished. While other factors have influenced the conservation of such buildings, the higher quality construction and more expensive materials

moved into Mona Gibson's old maternity home in Alameda and since "it was large and well-suited for Mrs. Wood to run a nursing home", she opened it to maternity cases rather than assist her husband at their dry goods store. From Dream to Reality, pg. 673.

¹³⁹For purposes of comparison, a representative house in both locations can be reviewed. Jessie Aimer's nursing home in Saskatoon was described by her in 1934 to be fully modern, having three rooms for patients, a bathroom, parlour, dining room, day room, kitchen, large glassed porch and full basement all heated by a hot air furnace. "Application Form for License (Jessie Aimer, April 2, 1934)" GS 64, PH 5, File 41, Department of Public Health-Nursing Division, SAB. Miss Eva J. Merrifield of Wolseley, in contrast, described her maternity home in 1933 as having four rooms in total, twelve windows, three outside doors and a cement basement. "Application Form for License (Eva J. Merrifield, March 23, 1933)", Ibid. In detailing the facility, those in smaller towns gave more comments on building materials (e.g. "brick") and which way the main rooms faced (e.g. "east fronting").

¹⁴⁰"Private Hospitals, Nursing Homes, Homes for Chronics, Aged and Infirm - Classification of Cases, 1940", table from GS 64, PH 4, file 9, Department of Public Health, SAB.

of big-city homes meant that they have lasted longer.

These smaller-centre maternity homes are usually described in detail by the Public Health Nurses on their inspection reports. The following description of Miss Thelma Wilson's home in Loverna contributes to an understanding of the average village nursing home:

The hospital is a little frame cottage equipped with one two bed ward, a private ward, kitchen, nurse's bedroom, dug out cellar, and a bassinette placed beside the mother's bed. The rooms contain a bed-side table, mat, chair, etc. and wash-stand with basin. The place is very clean and sanitary with good ventilation and fly-proof. There is a pump on the grounds, the water having been analyzed and the soft water has to be bought. There is no fire protection. For the disposal of waste, it is either burned or put in the ash pile. There is an outside toilet for the up patients and a disinfectant is used. There is an autoclave but it is not in use for sterilizing purposes. Miss Wilson uses the oven or else boils instruments, gloves, etc. on the stove. The hospital is not equipped with electricity or phone. The washing and ironing is done by hand. There is no stretcher as they use the bed for maternity work and (for) any surgical cases...all aseptic precautions are taken.¹⁴¹

Lack of space was a real problem for many nursing homes all across southern Saskatchewan.¹⁴² Often patients would be

¹⁴¹A letter to Miss R.M. Simpson, Regina, from Hilda M. Smith on June 16, 1933. The letter begins "Having inspected the nursing home conducted by Miss Thelma Wilson, R.N., Loverna, Sask., I am submitting my report as follows: GS 64, PH 5, File 39, Department of Public Health-Nursing Division, SAG.

¹⁴²A more detailed description of a bigger than average rural maternity home operated by Mrs. Annie Turcotte in Hudson Bay Junction may illustrate a home's lack of space. A public health nurse described the home as follows:

A two storey log building with a cement foundation. It

moved around the house, depending on what procedure was to take place and where the best heating and light, for example, was available. Rooms would be converted too, on demand, in the overall effort to make do under less than ideal circumstances. The Public Health Nurse inspecting Mrs. Bartels' home in Simpson stated that the "dining room is used for operating room such as tonsils, etc., all furniture removed and the room thoroughly cleaned."¹⁴³ Most matrons and their families would use whatever space was not taken up by patients.¹⁴⁴

Aside from a lack of space, most of the houses also did not have running water or plumbing systems in the early years. This was especially inconvenient when dealing with bedpans and in the winter season. Laundry, plentiful in a home where

is heated by a furnace and consists of ten rooms. Only the lower floor is used for patients and the lower floor has a three bed ward [15.5' x 13'], a two bed ward [15' x 9'], a single room [11' x 8'] and a combined caseroom and nursery [10' x 10']. They are of a good size and furnished with the necessary furniture as tables, etc., bright and appear to be sufficiently roomy. The upstairs has three rooms.

"Division of Public Health Nursing Private Hospitals and Nursing Homes Inspection Report (March 22, 1939)," GS 64, PH 5, File 39, Department of Public Health-Nursing Division, SAB.

¹⁴³Miss L. Lecerf, Public Health Nurse, October 21, 1943, "Division of Public Health Nursing Private Hospitals and Nursing Homes Inspection Report", *ibid*.

¹⁴⁴*Ibid*. When asked by E. Howes, Public Health Nurse, "Are Rooms used exclusively for patients?" in a March 16, 1944 Inspection Report, Mrs. Lacharite from St. Brieux, for example, replied "No, (rooms) are used by family when no patients". Mrs. Rachel Boyd Pitzen, whose mother operated a nursing home in Leader, also stated that "as kids, we often had to give up our beds during the night when an emergency came in". Jo-Ann Tetlock and Pattie Trautwein, editors, *Leader Lioness Club, Pages of the Past*, 1981, pg. 54.

infection was constantly feared, was hard work as it was done by hand throughout the 1930s and early 1940s with water that had usually been carried some distance. Mrs. Inglis' in Lumsden "at one time didn't have a washing machine, it was all done on the board and the clothes hung on the line and didn't have a well at the back door. She carried her water from down at the corner, about three blocks."¹⁴⁵ Electricity was also a luxury as late as the mid-1940s and the lack of it could be problematic:

We had coal oil light and the town itself had a generator for power and doc would go and tell Mr. Eccles (the station manager) that we had a case on. It was tricky because you couldn't have the coal oil lamp running in where there was chloroform. So we'd have lights for a bit, then the power would go dimmer, dimmer, sometimes it held out till the case was over and sometimes it didn't. Otherwise the lights went off at midnight.¹⁴⁶

Even a telephone in the early years was a luxury many maternity homes could not afford. Early applications for licenses do not even mention the use of telephones. Bessie Hill describes the process by which her aunt Mrs. Inglis called the doctor to a maternity case:

She didn't have a telephone so when they needed the doctor, they'd have to go down or she would run down and just knock on the window of the telephone office and the night operator then was Mr. Brooks and he would know. He'd say "Is that you, Mrs. Inglis?" and he'd phone for the doctor. The office was

¹⁴⁵Bessie Hill, Lumsden, 2 August 1995.

¹⁴⁶Edna Anderson, Estevan, 25 July 1995.

on main street, about two blocks away.¹⁴⁷

Dealing with special circumstances with little or no equipment proved that necessity was the mother of invention. Mrs. Inglis of Lumsden was famous for having used her 'doctor's' bag to save a very premature baby weighing just two pounds:

When dealing with premature babies, first a pillow was placed in the bottom of the (black club) bag, on top of that a hot water bottle which was covered by a blanket. She would then place the baby in the bag and insert a light in the top over the baby and put a cover over the entire bag, creating her own version of our modern day incubator.¹⁴⁸

Premature babies were also often wrapped in cotton batten and fed with an eye dropper.¹⁴⁹ Problems associated with breast feeding would also arise in the first ten days and were usually eased by the maternity home matron. Mabel Hultien had a unique treatment:

When a mother had too much milk, they'd get

¹⁴⁷Bessie Hill, Lumsden, 2 August 1995.

¹⁴⁸Author unknown, 1995. Taken from a display recreating Mrs. Inglis' maternity home in the Lumsden Museum entitled "The Cottage Hospital". This display contains many things from Mrs. Inglis' home including the famous black bag, birthing garments, weigh scales, bedpans and baby washtubs and is accompanied by an album of poems and photographs (see Appendix 9).

¹⁴⁹Donna Berard of Kindersley, SK. stated that "I feel I was a chosen child of God who has a purpose for me because I weighed only 3 pounds. To keep me alive, they (Mrs. Evans and the doctor) wrapped me in cotton batten and fed me with an eye dropper and they did it, I am a survivor". Mrs. Berard was born in Carlyle's Nursing Home in 1942, the fourth child her mother delivered at Mrs. Evans'. Donna Berard, personal correspondence with the author, Kindersley, 27 June 1995. Another premature baby was kept in a shoe box near the stove by Mrs. Josephine Storie, who put holes in the lid and fed the child with wet, sugar coated cheesecloth. Radisson and District Historical Society, Reflections of Radisson, 1902-1982, 1982, pg. 60.

caked breasts and we'd have to massage the breasts with camphorated oil. Mother was making pancakes for breakfast and got the brain wave - bit a hole in the centre of the pancake, let it cool a bit between her hands and went in and laid it on the woman's breast and she bound her up. Doc went in and said now, that's using your head. It really helped, the warmth and the grease on the pancake, just what she needed to loosen that breast.¹⁵⁰

The ever-present fear of infection meant maternity home nurses were generally very careful about sterilizing all medical supplies and this concern meant there were very few deaths due to infection.¹⁵¹ Considering the lack of modern equipment, this is quite an achievement. Nurse Scott's method of "sterilizing the bedding and everything else was to boil them for one hour and then iron everything,"¹⁵² a quite common technique. None of the Department of Health records for the early 1930s for example show evidence of any maternal deaths due to infection in private nursing homes.

Maternity home owners often then made the best of a situation and did whatever they could to address the situation, even when there was not much left to do:

She came in from way east...and she was too far along in her labour when they left home and so that baby was born with a brain injury but mother...I get all emotional even thinking

¹⁵⁰Edna Anderson, Estevan, 25 July 1995.

¹⁵¹Virtually every interview participant mentioned the measures taken to prevent infection in maternity homes. That this particular memory remained so strong reflects that the women had an especially strong fear of infection and perhaps that women, contrary to the reports of matrons to the government, were still dying in large numbers because of it.

¹⁵²Taking Root and Growing, pg. 376.

about it...because she was so loving with these babies...had they been born in a hospital, I don't think they would of survived. She [the injured baby] died finally when she was about seven years old. Mother took such good care of that baby.¹⁵³

Of course, despite the skills and experience of most matrons, it is very likely that from time to time, maternity homes lost patients that would have survived had they been attended to by a doctor in a modern hospital. While such a facility may not have been an option, the historical record should show that, on occasion, incompetence and accidents occurred in the treatment of patients in nursing homes that resulted in their deaths.

The information on maternity homes that can be gained in the local history books, government documents and in personal interviews is overwhelmingly positive. Perhaps due to a popular conservative political climate that automatically excludes unpleasantness from the 'good old days', virtually no one I interviewed expressed and no documents contained any direct criticism of maternity homes and the work done there more substantial than a comparison of food quality between homes in the same region. It would seem, because of the nature of community in rural Saskatchewan, that any mishap in a maternity home would be well-known in the area. However, the lack of condemnation points to another conclusion, that is, even after fifty years, people are reluctant to criticize

¹⁵³Muriel Jarvis, Saskatoon, 31 July 1995.

someone on whom they were once dependant for medical service. Rather than speak ill of the dead and have a misfortune in a nursing home revealed, most never mentioned any negative incidents.¹⁵⁴

One woman alone had a less than positive experience in a maternity home in 1949 and was willing to discuss it:

I went in three days before I had her...the water broke in the night three days before she was born...I don't think I ever saw the doctor until she was born. She called him at the very last minute...I was in labour for three days and I had what they called at that time a dry birth because the water had broken three days before...Apparently the doctor had said to her that the baby was small which (she) was, she was only just over five pounds and she was blue because I'd been in labour for so damn long. The doctor told her to put, to wrap that baby and get a hot water bottle on her to get her warmed up and she ran for the hot water bottle and the water was too hot and the cork wasn't put in properly and she put the baby on the hot water bottle, laid her on it. The weight of her body pushed the water out and it scalded her. It could be that [she was panicked because it was such a hard birth] - I thought I had an awful rough time. She was also getting on in years. I didn't actually know the baby was burned until the next day. I nursed her but I mean I never took her clothes off, you know, naturally I didn't know there was anything wrong with the baby. She told me

¹⁵⁴I had the opportunity to test most participants' reluctance to discuss unhappy events in the past after exploring the government documents in detail. In situations where I was sure that a mother or infant had died at a particular nursing home around the time that the research subject had worked or given birth there, I would enquire about the incident. The participants overwhelmingly answered that there had been no fatalities at the home in question. While many years have passed and such a detail could easily be forgotten, it would seem that every member in a small community would have been aware of a misadventure that had occurred in the local home. The research subjects generally had a greater tendency to disparage the doctor rather than the matron. Thus this thesis has adopted the tone of 'evil physician' and 'hero matron' to a great extent because of the partiality inherent in the personal interviews.

the next day, she said I had an accident with the baby and I burned her. She had stated at that time that she would pay for any operations or anything the baby had to have done but we had medicare by then anyway. It was an accident. Maybe she wanted to get back to me in a hurry. I don't know if people paid her...I know I certainly never paid her.¹⁵⁵

In contradiction to the post-industrial focus on the product at the expense of the producer, there is a distinct feeling in the records and interviews that the life of the mother was of more importance than that of the child in crisis deliveries and that sentiment is probably reflected in the low maternal mortality rate as compared to the infant mortality rate throughout the 1930s and 1940s. While by 1932 Saskatchewan had the best record on maternal deaths (4.4 per 1000 births), it was ranked fourth in infant mortality.¹⁵⁶ Early in the settlement years, figures on maternal mortality were inconclusive and then appeared shockingly high when calculated and published in the Department of Health's Annual Reports. While Saskatchewan had the lowest rate in all of Canada, a high maternal mortality rate was associated in the province with hospitals and the presence of a doctor for a number of reasons. The Shaunavon Standard reported the following in the fall of 1932:

¹⁵⁵Laurel Valentine, interview by the author, tape recording, Rocky Mountain House, AB., 21 August 1995. The baby underwent two years of skin-grafting procedures and the scarring was extensive (over twenty percent of her body suffered third degree burns).

¹⁵⁶The Shaunavon Standard, "Saskatchewan Had Lowest Maternal Mortality in Canada", October 13, 1932.

In Saskatchewan in 1931 there were 93 maternal deaths. Of this number 60 occurred in hospitals. Of the 33 deaths which took place outside of hospitals, 31 were attended by physicians, so that only two out of the 93 cases were without medical attention.¹⁵⁷

Mention then of maternal deaths is very rare. As the nursing home served the community, a loss of one of its members there caused considerable heartache and stayed with the citizenry for many years.¹⁵⁸ Interestingly, the cause of maternal death, both in the local history books and during interviews, is rarely in co-ordination with the most common pathological origins. While maternal deaths were statistically attributed to "puerperal infection, toxæmia, hæmorrhage, dystocia or prolonged labour, and shock,"¹⁵⁹ the blame, if any, was placed firmly on the mother and her actions throughout her pregnancy:

She lost a mother, in fact, it was a relative of theirs. I guess she hadn't really taken care of herself very well, she didn't exercise or anything so she wasn't in very good condition but I'm not sure why she died and the baby lived. The grandmother raised it.¹⁶⁰

¹⁵⁷The Shaunavon Standard, "Saskatchewan the Healthiest Spot", September 15, 1932.

¹⁵⁸This was especially true when one of the family died in childbirth, as happened in Annie Bradley's nursing home in Cadillac. A close relative through marriage, Irene Bradley, died there after her daughter was born in December of 1935. Cadillac Prairie Heritage, pg. 566.

¹⁵⁹Dianne Dodd, "Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women," pg. 151.

¹⁶⁰Mable Bradley, Saskatoon, 31 July 1995. Mrs. Bradley is the daughter-in-law of Mrs. Annie Bradley, who ran the Cadillac nursing home for over twenty years. The idea that this women had lost her life because she failed to take care of herself during her pregnancy was no doubt a common conclusion at the time and constructed by both the matron and the doctor.

Stillbirths, which happened with more regularity, and the death of infants shortly after birth, also were thought to be a result of some action of the mother, whether accidental or not:

We lost only one baby and that was a mother that was chasing the cattle in the pasture and she fell in a badger hole right on her stomach so the baby was born too early.¹⁶¹

Interestingly, virtually all infant deaths occurring in nursing homes are listed in the "Report(s) of Private Hospital or Nursing Home" as stillbirths. Perhaps other kinds of deaths were labelled stillbirths in order to camouflage the fault of either the matron or attending doctor or some technological shortcoming of the facility itself. References to problems with breathing, deformity, and abnormal presentations that required the doctor or matron to kill the child in order to save the mother are non-existent. As infant mortality figures do not include stillbirths, it is obvious that of the portion that do not make it through their first year, some must have died shortly after birth while in the nursing home. Both infant and maternal deaths and the fear of such played a large role in the decision of where to give birth, as the following chapter explores.

¹⁶¹Edna Anderson, Estevan, 25 July 1995.

Chapter Four

That the feelings of isolation rural women in Saskatchewan experienced were heightened during pregnancy is obvious. These sentiments would of course vary depending on the area of the province and one's personal background. While physical isolation was most predominant during the settlement period in the

Figure 3A busy February 1943 at the Midale Maternity Home.

province, the upset of the Depression was also very gruelling for women outside of urban areas. T.C. Douglas acknowledged that women often suffered the most from isolation in the 1930s.¹⁶² While the train often linked town to town, car travel from town to one's homestead was often tentative. Roads were usually in poor condition and depended greatly on weather conditions. Gas for these vehicles was expensive to purchase during the Depression and was rationed in the war years. While Georgina Taylor has theorized that this

¹⁶²Tommy Douglas, "The Highlights of the Dirty Thirties," in The Dirty Thirties in Canada R.D. Francis and H. Ganzevoort, eds. (Vancouver: Tantalus Research Limited, 1980), pg. 165.

isolation led many women to join the Homemakers' Club, the United Farmers of Canada Saskatchewan Section and the Co-operative Commonwealth Federation,¹⁶³ it seems likely that feelings of isolation were also eased when one came into town to deliver a baby.

Women had, and still were to a smaller extent, delivering babies at home but by no means was that desirable to most women. The fear and anxiety involved in giving birth far from any medical convenience had only been multiplied with the governmental concern about infant and maternal mortality rates in the 1920s and 1930s. Fear of the physical trial of pregnancy and childbirth naturally increased in isolated areas where medical assistance was relatively distant and fairly expensive. Women had always relied greatly upon other women during childbirth in the prairies - even one baby made a woman an expert in the eyes of a first time mother. Sisters, mothers and neighbours all were called upon to assist during birth and the event provided another chance for women to become closer by sharing the experience with one another. In certain areas, some women would be singled out because of their great experience of the process to become midwives. Usually these women had no formal medical training but were

¹⁶³The foregoing argument detailing the conditions of isolation of rural women in Saskatchewan is formed by Georgina Taylor in "'Should I Drown Myself Now or Later?' The Isolation of Rural Women in Saskatchewan and Their Participation in the Homemakers' Clubs, the Farm Movement and the Co-operative Commonwealth Federation, 1910-1967" in Women: Isolation and Bonding, The Ecology of Gender Kathleen Storrie, ed. (Saskatoon: Canadian Research Institute for the Advancement of Women, 1987), pg. 79-100.

trusted and welcomed into the home. It is largely these women who went on to open maternity homes in urban areas rather than continue to assist in the patient's home. The absence of these women in the countryside meant parturient women would have to go to the nurse.

If because of timing or extreme geographic isolation, no one came to assist in the childbirth process and the woman was unable to arrange transportation into the city, women gave birth completely alone. This, of course, was not the ideal situation but many women had perfectly normal births with no complications under these conditions and became used to it:

I had all twelve of them without any Doctor or woman...the last baby that was born I stood up and caught him in my arms and laid him on the bed and reached over and got the scissors and separated the cord.¹⁶⁴

It can be assumed that although having a doctor or midwife was preferable, women who were able to give birth alone, and successfully, felt considerable pride. If having a child was an accomplishment and cause for respect from the community, then surely the respect was increased if a woman could be strong and not burden others with such a natural biological process. Because they were socialized to believe having children and nurturing them was their biological personal destiny, giving birth alone was acceptable and re-emphasized that children and their development, in theory, was

¹⁶⁴This quote is dated around 1900. Linda Rasmussen, Loran Rasmussen, Candace Savage and Anne Wheeler, A Harvest Yet to Reap: A History of Prairie Women (Toronto: The Women's Press, 1976), pg. 76.

the woman's responsibility to deal with unaided by others.

"Going to town" apparently originated in the British aristocracy of the mid eighteenth century and involved a parturient woman travelling to an urban area to give birth.¹⁶⁵ While these trips may be consistent with the more public notion of childbirth, "going to town" also meant that childbirth was an exciting event in more ways than one. The upper class nature of "going to town" manifested itself on the prairies as well. Transportation to the nearest small town had to be arranged to give birth in a maternity home. In addition, it usually meant leaving older children at home. In any case, it is possible that "making practical arrangements for the birth of a child may have helped to reduce the tension and tedium of awaiting the onset of labour."¹⁶⁶ Consequently, "going to town" reduced the fears and anxieties of expectant mothers.

The decision whether or not to go into town involved a balancing of fears. A woman about to give birth had a number of factors to consider in the face of a decrease in midwives who would come out to an isolated farmstead. The services of such a woman would be cheaper than a doctor and she would also take care of the home and other children but many of them had

¹⁶⁵Judith Lewis, In the Family Way: Childbearing in the British Aristocracy, 1760-1860 (New Brunswick, NJ: Rutgers University Press, 1986), pg. 156-157.

¹⁶⁶Sylvia Hoffert, Private Matters: American Attitudes Toward Childbearing and Infant Nurture in the Urban North, 1800-1860 (Chicago: University of Illinois Press, 1989), pg. 46.

located themselves in the area's villages. If she hired an expensive doctor to come to her home, it was likely that she would not receive an appropriate amount of rest either before or after delivery, harming both herself and her baby. If she decided to go to a maternity home and allow herself the luxury of getting some rest while someone else took care of her, medical experts at that time warned that the ride to such a home might injure her and the baby. During the years in which the opening of maternity homes was on the upswing (the early 1920s), infant mortality rates were affected in the following ways:

Table 3

The Percentage of Infant Deaths by Stillbirth, Prematurity and Congenital Debility due to "Overwork by Mother," 1920-1923

	1920	1921	1922	1923
stillbirths	4.91	2.83	2.67	3.04
prematurity	11.30	14.67	8.74	11.22
congenital debility	---	5.41	3.03	4.00

Table 4

The Percentage of Infant Deaths by Stillbirth, Prematurity
and Congenital Debility due to "Trip Taken by Mother,"¹⁶⁷
1920-1923

	1920	1921	1922	1923
stillbirths	0.61	1.41	2.00	0.38
prematurity	3.48	4.67	5.83	8.16
congenital debility	---	2.70	---	---

In all cases then, it is shown that taking the trip into the maternity home was of less risk than staying home and not getting the rest necessary to insure healthy baby and mother. I would argue that this was common knowledge and contributed to the popularity of maternity homes in southern Saskatchewan.

At the same time as pioneer strength and fortitude played its role in where women would give birth, the pressures of isolation by the early 1930s largely meant women would come to

¹⁶⁷The term "Trip taken by mother" was usually used interchangeably with "Long Trip taken by mother". For all years in at least one of three causes of mortality, the terms "Rough ride/drive taken by mother" or "Motoring by mother" are also used. Where both are used, the figures have been added. While the term "overwork" here does not mean overwork immediately before and after birth but overwork throughout one's pregnancy, it can be assumed that conditions were such that the woman would not be allowed to stop working for long. Statistics are taken from the Annual Reports 1920-1923, Department of Health.

town and the local maternity home. For rural women, the time of year and the weather played the biggest role in deciding at what point a woman would be admitted to a maternity home. While the majority of summer births took place on the same day as admission, those in the winter and spring were days and sometimes weeks after a woman had come to town. Women who lived nearer the nursing home had more flexibility as to when they checked in:

It depended if it was wintertime. Back in that area (Fife Lake), snow would get pretty deep which it still does and they would be worried about getting to there well they would come in two or three days ahead of time or maybe even a week because they didn't want to be caught at home and then mom couldn't get to them and they couldn't get to her. So what would ever happen then, eh?¹⁶⁸

The hazards of travel to town were not to be underestimated. Transportation in getting to the home was often dictated by the weather as Marie Raynard states:

One night a woman arrived at the nursing home exhausted. She'd travelled with Dr. Mainprize and his driver in their snowmobile over twenty miles of drifts and impassable terrain. She looked frozen and as her coat was covered in snow, I gathered that they'd been stuck several times and she said that she either pushed or stood beside the snowmobile while one of the men pushed. Apparently, she was none the worse for her experience, because forty minutes after her arrival, she gave birth to a healthy, bouncing baby boy!¹⁶⁹

¹⁶⁸Penny Hansen, Red Deer, AB., 29 August 1995.

¹⁶⁹Marie Raynard quoted at length in The Country Doctors pg. 232-233. Henri Chatenay, Echoes of Silence: The Chronicles of W.G. Mainprize, M.D., 1911-1974 (Red Deer, AB: self-published by the author, 1978), pg. 26 claims that Mainprize's prototype snowmobile, designed in 1938, was solely

Obviously, the nursing home played a major role in the accepted scenario of childbirth. If the doctor had gone out to pick the woman up, he could technically have assisted in delivery at her place of residence. To risk delivery in the outdoors in order to reach the nursing home speaks to the home's importance. Other women spent more time in the home as the weather and distance required and for at least one person, extreme measures were needed to get home:

I arrived quite a few days early due to the winter of 1947, one of the worst winters we've had in years. In fact, we couldn't get there directly (from a farm 60 miles from the nursing home), we had to drive a 100 and some miles to Regina, stay there over night and drive back 80 miles or so to Midale and then I was there a good thirteen days before the baby arrived. It was a long procedure...We became pretty good friends...I stayed longer than I was supposed to stay due to the winter. There was a storm everyday it seemed like and it was so cold and there was no way of anyone coming to get me because the roads were all blocked so eventually I flew home by plane, right to our gate. I had to be the navigator and tell the pilot where to land.¹⁷⁰

It was not always the patient who wanted to come into town to a maternity home. While coming into town might ease some of the fears of parturient women, it was also much more convenient for the doctor. One woman stated that she thought "maybe the doctor preferred it, you know. He lived right here

developed "to transport maternity patients to Hultien's nursing home", which goes further to prove how important the home was to treating maternity patients.

¹⁷⁰Marie Raynard, interview by the author, tape recording, Kenosee Lake, 23 July 1995. Cost was obviously not a big factor to the Raynards after being away from home for so long with a new baby.

in town."¹⁷¹

Saskatchewan's system of maternity grants also encouraged women to give birth in a place other than their own homes. As early as 1913, an amount of cash was available for the purposes of "securing competent medical attendance at birth, as well as supplying the necessary articles for that important event." Only those who for financial or other reason could not otherwise see a doctor and leave the place of residence were eligible, which meant that most women in rural areas could get the grant. Fifteen dollars was distributed to the attendant while ten dollars was given directly to the mother.¹⁷² This twenty-five dollars remained the standard for many years. In 1923, the Department of Health clarified that the fifteen dollars could be "given to the doctor, hospital or nurse at the discretion of the Deputy Minister, to assist in obtaining such services."¹⁷³ Through the maternity grant, women in need had some money to offer a maternity home matron for her services. In this era, a doctor would be called less often so the matron would be entitled and qualified to receive the entire fifteen dollars. In later years, the doctor no doubt received the bulk of the payment while the matron got

¹⁷¹Bessie Hill, Lumsden, 2 August 1995.

¹⁷²Annual Report 1914, Department of Health, pg. 46. Application for the maternity grant was to be made through the Registrar of Births, Marriages and Deaths in the local district, which meant one got the money quite a time after their baby's birth.

¹⁷³Annual Report 1923, Department of Health, pg. 45.

some small portion. The grant obviously meant that women were encouraged to come to nursing homes for attention as they were more likely to find assistance there for the money they could offer. Ironically, the grant was discontinued in 1931 due to an ever-increasing demand, just when most mothers needed its benefits. Outlays for the project had increased from \$441 in 1919 to \$64,116 by 1930. The grant was changed to an inexpensive 'maternity package' which included "a layette for the infant and some supplies for the mother."¹⁷⁴ By the early 1930s however, maternity homes were well-established and popular and, even without availability of the grant, were used by women who may or may not have been able to pay for the care they received.

Not all patients were referred to maternity homes by a doctor and some births, especially in the early years, were conducted solely by the matron herself.¹⁷⁵ Aside from the availability of doctors, there are three probable reasons that some women and their families chose not to hire the local doctor and go to hospital, if that was an option. Firstly, doctors were sometimes outsiders and did not necessarily intend to stay on for an extended period of time, arriving after maternity services had been adequately supplied by a

¹⁷⁴"Resume of Work of Department of Public Health, 1931", R194.2 GR 39-1 File 70, Department of Public Health, pg. 14, SAB.

¹⁷⁵In Avonlea, for example, Mrs. Annie Watson, assisted in the delivery of many babies while "more serious medical problems were handled in Rouleau hospital...when weather, transportation and finances permitted". Arrowheads to Wheatfields, pg. 64.

local woman with strong community ties:

I guess we made the choice because she had delivered hundreds of babies before we had Alan and she was more than capable and she was such a dear friend and a very dear person. And all you need is faith and we believed she was every bit as good as a doctor. I don't think you could've got any better service in a hospital than you got at Mrs. Evans'.¹⁷⁶ Until she retired, people just went to her.

In addition to the community ties matrons had, they also provided pre- and post-natal care as a matter of course. It would only make sense to use a nursing home if that person had already taken care of the woman's pre-natal medical needs and was committed to checking up repeatedly after the birth, all included in the fees incurred while actually staying at the home. Doctors, on the other hand, charged for such calls and gave them less priority. Doctors who had not 'proven' themselves to the community would not be called except in cases of extreme emergency. Secondly, cost was a major factor. Those with no money for a doctor's services would often wait until the patient was close to death to call an expensive doctor. "With a variety of homemade remedies and the aid of an experienced neighbour, many thought they could avoid a cost which, if the patient recovered, would have proved to have been unnecessary."¹⁷⁷ The association of doctors with death was common. Doctors had a reputation for being expensive, and most people believed that the costs of

¹⁷⁶Alma Miller, Carlyle, 5 August 1995.

¹⁷⁷Angela Boyd, Pioneer Health, pg. 21.

health care far outweighed the actual work done.¹⁷⁸ Thirdly, in areas where hospitals were available, people still associated them with charity and disease. There was a distinct stigma in the early years because indigents who could not afford other services used hospitals and they had first been constructed for use as isolation buildings to fight the many epidemics Saskatchewan suffered. When contrasted with the services practical nurses provided and the low cost of these services, certain hesitations in the early years of the century about doctors and hospitals make sense. These hesitations seriously tempered any respect and status a doctor could gain in an area and increased the volume of business in a maternity home.

The care women received in the nursing home meant a bit of a break from their normal routine of farm, child, and house work.¹⁷⁹ They were required by the doctor and matron to remain in bed for at least ten days and their meals and the bed pan were brought to the bed. They were free then, aside

¹⁷⁸A common joke of the time, one that has survived in some form or another even today, to some degree illustrates the contradictory sentiments that rural prairie people had toward doctors. They were both respectful and suspicious:

Patient: Well, doc, you sure kept your promise when you said you'd have me walking again in a month.

Doctor: Well, well, that's fine.

Patient: Yes, I had to sell my car when I got your bill.

The Maple Creek News, February 2, 1933. Vol. XIX, No.15, pg. 1, Maple Creek, SK.

¹⁷⁹I am attempting in the next two paragraphs to set the scene in an average maternity home. While Alma Miller said "Well, let me tell you, it'd be just like if you were short-taken right here and they'd put you in on the couch" (Carlyle, 5 August 1995), the following points are true for all the homes I looked at and give a better idea of what went on in them in terms the care given to maternity cases.

from feeding their babies, to read and visit with the other women. The medical treatment given them was surprisingly adequate and in keeping with the pioneer spirit of home remedies and common-sense solutions. Beds were covered with Kelly pads to protect the bed coverings¹⁸⁰ from being soiled. Often beds were set up on jam pails so as to be at a more convenient height for those assisting. The pails could then be knocked out at one end if a women began to haemorrhage.¹⁸¹ Mothers were bound around the abdomen with scrap cloth in an attempt to push the uterus back into position. In case of too much milk flow or if the mother did not intend to breast feed, the chest was bound as well. Newborn babies wore binders made of the same materials to prevent hernias and to keep the naval clean and dry. Enemas were given to the mothers-to-be as a matter of course. Castor oil was also administered in this regard. Epsom salts were used to dry up breast milk. Menstrual pads, which the home supplied, were homemade from absorbent cotton and cheesecloth and sterilized thoroughly in the oven.

Newborns were often kept in a room separate from the

¹⁸⁰For a description of Kelly pads, see Sharon Reilly, "Material History and the History of Women" in First Days, Fighting Days: Women in Manitoba History, Mary Kinnear, ed. (Regina: Canadian Plains Research Center, 1987), pg. 7-8. Reilly calls this item a birthing mat while many women I talked to called it a Kelly pad. No one knew the origin of the name.

¹⁸¹Edna Anderson, Estevan, 25 July 1995. The beds were not modern hospital beds but normal household beds. Mrs. Anderson reports that she knew there was a problem when "Doc would grab a hold on the bed and kick away the jam pails and slope the bed so the head was down and then start packing gauze in to stop the bleeding."

mothers in order to allow both to rest and because the kitchen, for example, was kept at a warmer temperature than the rooms where patients had their beds. The matron or someone assisting her would bring the baby in when the mother asked or it was feeding time. Portable screens were commonplace in nursing homes and provided some privacy in multi-bed rooms. Depending on availability and one's situation, private rooms could be secured but there was not a very high demand for such accommodation. Because there was always more than one bed for patients in a nursing home and the home usually served quite a large region, more than one maternity case at a time was normal.¹⁸² Margaret Inglis had as many as five at a time¹⁸³ and two at least was not rare. Ideally, the women would be on their own in the house until the labour reached such a stage where the head was visible and then the doctor arrived to deliver the baby. Usually, the doctor would in normal situations pay at least one post-natal visit to the patient before she left the home and other than that, the matron was responsible for all other duties.

Especially in homes where the matron was widowed, the doctor became the most visible man in the nursing home. While

¹⁸²Ibid. Edna Anderson claimed that having more than one patient at a time was not especially difficult, up until to a certain point, because the same chores had to be done anyway and only the volume increased. She claimed it was handy in many ways, not the least of which were feeding problems. She said "if we had a mother that was giving too much milk and some other mother didn't have enough, well, we'd just give her another baby and let her feed both". This no doubt increased the bonding between women in the maternity home.

¹⁸³Bessie Hill, Lumsden, 2 August 1995.

he retained prestige because of his position, patients were conscious that his male presence violated a strictly women's space¹⁸⁴ and thus he could be made fun of in a non-aggressive manner. One of Mabel Hultien's patients remembers this conversation:

Edna: Look she's knitting, always
doing something.
Mrs. Anderson: Wait, she won't be after she
has as many as me, will she,
Doc?
Doc: Well I don't know, I've never
had any.
Myself: No, but you've sure been
responsible for a lot!¹⁸⁵

While childbirth was a stressful occasion, it would seem that women together in maternity homes took every opportunity to chat and have fun, a prairie adaptation of the age old practice of "calling women together". Part of the traditional childbirthing experience included an all-female group of attendants and supporters. When a woman went into labour, she would "call her women together,"¹⁸⁶ assembling friends and family in the delivery room to share encouragement and advice.

¹⁸⁴There is some variation on the subject of whether or not husbands were allowed in the delivery room, which I would argue means that the individual maternity home matron and her opinion probably exerted the major influence in making such a decision. While Gertie White, who delivered in a Gull Lake nursing home, claimed there was "no stupid stuff like that...it was women's work. I wouldn't go for that at all" (Interview by the author, tape recording, Rocky Mountain House, AB., 30 August 1995), Edna Anderson, who gave birth at her mother's home in Midale, stated "if we needed help, the doctor would go in the kitchen and get the dad and say 'C'mon you, you've been here before'. Quite a few men came into the delivery room. (My husband) came in with me" (Estevan, 25 July 1995).

¹⁸⁵Mrs. Hultien's autograph books, written by "Happy Go Lucky Dorothea Geske" who had a son on January 12, 1943.

¹⁸⁶Judith Leavitt, "'Science' Enters the Birthing Room", 281.

Because women in the west may not have had wide support networks available but still needed them, giving birth in a maternity home provided an environment dominated by women. Evidence of the personal connections made here come up in recollections about the childbirth experience; everyone I interviewed remembered which other women were in the home when they themselves delivered each of their children. Mabel Hultien's home, for example, was filled with "giggles and laughs" in the opinion of most of her patients.¹⁸⁷ Even when tragedy occurred, a group of women could lend sympathy and support.¹⁸⁸ The notion of these women together constituting a family comes up again and again. One of the six women who gave birth at the Midale home in the first two weeks of February, 1944 gave a good insight into what a houseful of new mothers and babies was like:

What a family we were eh? So many good laughs, talks, etc. Remember the night when No b. came along when the "stork" got its verdict? Hope you'll both have a nice rest

¹⁸⁷Almost without exception, the entries in Mrs. Hultien's autograph books mention "the laughs we had to pass the time" (Rogna Gordon). Others mentioned that "the time did not seem so long for there was a lot of talk and laughs" (Elizabeth Baudria) and "remember the jolly times we had" (Dorothy Peterson). While those who had suffered a bad experience in this home probably would not have mentioned it in these books, one gets the overall impression that going to a maternity home was enjoyable for the visiting aspect of it.

¹⁸⁸Mrs. Mildred Dupuis wrote "I sure will miss you and Edna when I get back home as you folks made me forget my sorry". Mrs. Dupuis had a ten pound baby girl after a long birth and many complications at the Hultien Home in Midale. Quote from Mrs. Hultien's autograph books.

after we all leave.¹⁸⁹

And another stated:

It felt so good to come back to you. What a wonderful time its been re-uniting family and friendship ties. Thank you again for this golden opportunity and good care.¹⁹⁰

That solid ties of friendship developed is obvious in the interest both matron and patient¹⁹¹ had in keeping in touch and following the lives of children born there. Often patients would send back pictures of their children and matrons would call them "my babies". Mabel Hultien had several of her babies visit the house on their wedding days as brides in their veils and gowns to show her how they looked, all grown up,¹⁹² while Nurse Martha Sinclair's first customer named her baby after the woman who had assisted her.¹⁹³ Even in death, the connection remained between a matron and the

¹⁸⁹Ruth Pe(d)erson of Bromhead, SK. in Mrs. Hultien's autograph books. That Mrs. Hultien and her daughter Edna were reaching the end of their ropes is obvious in the next entry which reads "Remember the 6th guest who upset the household at midnight and the stork was threatened by Edna" (Evelyn Manley).

¹⁹⁰Edith Larson writing in Mrs. Hultien's autograph book. Mrs. Larson gave birth to a baby boy in July of 1944.

¹⁹¹Blanche Wilkie wrote in Mrs. Hultien's autograph book "And Edna didn't you like the way I hugged you 1/2 doz. times daily?". She had a son in May of 1944. Edna was a favourite of the patients in her mother's maternity home.

¹⁹²Edna Anderson, Estevan, 25 July 1995.

¹⁹³The practice of naming female babies after the matron that assisted in their delivery is not at all uncommon. One such incidence, reflective of both the respect given to maternity home matrons and to the settling of towns and villages, was the birth of Lily Martha Climax East in 1923. This little girl was named Lily after her mother, Martha after the matron and Climax after the town in which she was born. Stone Diggers Historical Society, Prairie Wool: A History of Climax and Surrounding School Districts, 1980, pg. 34.

babies she had delivered. Annie Bradley was one of many matrons to be carried to her funeral plot by six men she had seen brought into the world.¹⁹⁴

In addition to visiting and building friendships based on common experiences, maternity homes also became a place where women could exchange information on birth control, the birth process itself and child rearing. Of course in an age when frank discussion of such issues was not totally acceptable, some women were not aware of certain points of information. Mabel Bradley gives an example of how her mother-in-law lost her patience with one naive woman:

This one time, this one gal was in, young and her first baby, and she was so afraid. She was having quite a time with this birth, the baby wasn't coming, baby wasn't coming and she yells 'hurry up and get this baby out'. She wanted mother to cut it out. Well, she said, I'm not going to cut it out. Well, the girl said, how's it goin' get out? And she said well, it'll get out the same way it got in! The gal was so flabbergasted. All ready to have a baby and didn't know how it would be. Imagine!¹⁹⁵

The operators of nursing homes attempted to address this lack of information the best they could and act in other ways that would help women in the community. Firstly, maternity home matrons often gathered print information from the provincial department of health in bulk to distribute in their

¹⁹⁴Mabel Bradley, Saskatoon, 31 July 1995.

¹⁹⁵Mabel Bradley, Saskatoon, 31 July 1995.

communities.¹⁹⁶ Secondly, they encouraged the women themselves to discuss, no doubt, ways in which to limit family size and other tips that could be relayed in a women's only space. Thirdly, a maternity home could also serve as a haven for women in stressful situations. As a woman's space, perhaps women felt comfortable going there for reasons other than childbirth:

We had one lady here, had marital problems. It was bad in her home and doc wanted her to stay with us so we could watch her. And we had to watch her so she didn't get into our medicine cabinet and take aspirins or too much of anything and she was a nervous wreck. To make it legal that he wasn't providing for her, she went and slept on a bench in public so it looked like she was without a home. But she got stronger eventually and everything worked out.¹⁹⁷

While referral by a doctor would sometimes be the first contact a woman had with a certain maternity home, once a woman gave birth somewhere she often returned there again if

¹⁹⁶Inspection reports by Public Health Nurses often include notations like "Mrs. Edmunds (Maryfield) would be glad to receive pre-natal, post-natal and infant literature for her patients", "Division of Public Health Nursing Private Hospitals and Nursing Homes Inspection Reports (February 28, 1939)" GS 64, PH 5, Files 39, 40 and 41, Department of Public Health, SAB.

¹⁹⁷Edna Anderson, Estevan, 25 July 1995. Reports of maternity homes acting as a precursor to social services appear elsewhere. Mrs. Dyon in Antler took in the homeless and abandoned children as well as running a maternity service. Her grandson stated "I often wonder if she ever made anything out of her labour, because from what I have been told and what I recall, she was half the time looking after some waif or raising somebody else's kids." Footprints in the Sands of Time, pg. 106. Another example would be Mrs. Elizabeth Parker of Assiniboia, who would leave her maternity home to accompany a prisoner or patient to the mental ward in Weyburn, acting as a 'police matron'. The History Committee, Heritage '85: Town of Assiniboia, 1985, pg. 315. Earlier than that, Anne Moore was called on to treat shell-shocked World War I vets in her home town of Biggar. She was apparently the only one able to handle the violent attacks that were part of the affliction. North Biggar History Book Committee, North Biggar History, Volumes 1 and 2, 1986, pg. 624.

the service was good. The Midale home had many return customers:

I don't think there was a patient that didn't hug and kiss us when they left. This was a home atmosphere - I think that's why they got well so fast, too. It was like a holiday for them. And we'd always, when we'd say goodbye to them, say "well, we'll see you next year!". There was one lady, she was a steady customer. She had twelve, most of them at our house, all as fast as they could plant them.¹⁹⁸

A number of criteria are appropriate in looking at those who had their children in maternity homes, such as their class, ethnic and religious backgrounds, political affiliations, average age and marital status.¹⁹⁹ Religious and racial barriers to entry were less stringent than those in the east, largely due to the homes' motivation for profit and the vast number and variety of immigrants throughout the province. Generally, religion seems to have been the less influential factor of the two in who was encouraged to give birth in a maternity home. While maternity home matrons may have subscribed to some religion, women of all denominations in the area were welcome to come there for confinement. Where parturient women had made the commitment to go a nursing home and had a choice between two or three maternity homes in their area, religion may have played a bigger role in deciding which

¹⁹⁸Edna Anderson, Estevan, 25 July 1995.

¹⁹⁹See Appendix 11 for such a profile of the customers who used Mrs. Inglis' home in Lumsden.

to patronize.²⁰⁰ The religion of the customers, while it appears not to have been used as an yardstick for the quality of service, was definitely a point of information of which the matron was aware:

One time there was things she had to do with this one baby that died. Seems to me it was Catholic but she baptised it because she knew it would die before the priest got there and she knew it was one thing they'd like to have done. I don't know what she did but she said and did the proper things. She belonged to the United Church and had a lifetime membership there.²⁰¹

Race may have played a bigger part in the use of maternity homes, especially so for so-called visible minorities like Blacks and Asians, for example.²⁰² Birth announcements in certain areas cover a wide nationality range of surnames, but do not allow us a definite look at race (see

²⁰⁰If a choice of maternity homes was available and either were openly denominational, it was quite likely that a family would chose the home of one of their own church's members. In Antler for example, "it has been said that usually the Protestants went to Mrs. Scott's and the Catholics went to Mrs. Early's where baptismal ceremonies were sometimes performed." Footprints in the Sands of Time, pg. 159.

²⁰¹Mabel Bradley, Saskatoon, 31 July 1995. This story is not as uncommon as one may think. There are several other reports of matrons being as religiously sensitive in their maternity home businesses, particularly in the area of baptism, whether doing it themselves or allowing members of the clergy to come into their homes.

²⁰²Howard Palmer, Patterns of Prejudice: A History of Nativism in Alberta (Toronto: McClelland and Stewart Ltd., 1982). While Palmer is referring specifically to Alberta, it can be safely said that a racial pecking order was in use right across Canada. I would argue that maternity home owners were less likely to be prejudiced against a women of a certain ethnic background than against the woman's husband. Through institutions like the nursing home, women had more cross-cultural contact with each other than men did. If understanding lessens racist views, then women who knew each other on the personal level of childbirth would be less racist. Still, while white women from different points in the hierarchy gave birth in maternity homes, there is no evidence of whether their actual care there was influenced by their position.

Appendix 12). Like other institutions, practices and actions on the prairies within this time frame, maternity homes were no doubt subject to the dominant group's idea of an ethnic hierarchy to some subtle extent²⁰³. During the years of massive immigration, there was not generally a warm welcome for immigrants of other than British origin. And while a number of the newcomers were from the United Kingdom, only those non-English-speaking immigrants were seen as undesirable strangers. Difference meant deviance. It was accepted in this time period that ethnic and racial groups varied in character, intellectual ability and potential for success on the prairies. At the top of the ethnic 'pecking order' were British and American immigrants, most obviously because their similar cultural backgrounds fit into the federal government's idea of what western society should be like.²⁰⁴ Next were immigrants of German and Scandinavian origin, who were viewed as industrious workers and readily assimilable. Following this group were the central and eastern Europeans. The Jewish, Italians and Greeks were not thought to be good on the land but it was the Ukrainians and the Doukhobors who were

203This is illustrated in the comment that, during her dealings with expectant mothers, Jane Blake of Strasbourg "retained some of the upper class English dignity but did not let it interfere with business or work". Strasbourg, Bulyea and Duval History Book Committee, Between Long Lake and Last Mountain: Bulyea, Duval and Strasbourg, Volumes 1 and 2, 1982, pg. 323.

204England, the United States and Germany were popularly viewed as 'first class nations'. The inclusion of Germany in this designated category reflects the historic ties between Britain and Germany rather than any sort of racial analysis.

singled out for hostility most often of any 'white' groups, perhaps due more to the effect the large numbers of immigrants from this location had on how much free land was available rather than any supposedly undesirable racial characteristics. The groups that made up the bottom of the racial hierarchy were, not surprisingly, non-whites such as the Chinese, Japanese, Sikh and Black immigrants. These groups suffered the most intense racial prejudice because complete assimilation was seen to be impossible. It was by these standards that ethnic discrimination and racism operated in the prairies.

While all manner of Anglo-Saxons and Europeans were, as part of the dominant ethnic character of the area, using maternity homes (how they were treated once they were there can not be explored), no evidence of any person of colour giving birth in a maternity home can be found. The periodic exception to this is Native women. Where a nursing home was situated near a reserve, occasionally Native women would come to a maternity home, apparently largely out of respect for a matron's midwifery skills, skills they may have first witnessed on the matron's monthly health care trips to the reserve. Most Native births then were not assisted by a doctor, ostensibly because the Native women did not want them present. A doctor in that era had the overall impression that Native women had a significant predisposition for isolation at delivery time:

I was never called to see a patient who wasn't in a really serious condition and in great need of my help...Indian women had an interesting tendency to hide during their labour, basically to protect themselves and their newborn babies from the enemy....In those days we were trained to keep mothers strictly in bed for ten days following the birth of a child, but the Indians did not believe in this. To them it was taboo. The mother was usually up and on her feet and about her duties the next day.²⁰⁵

As an added disincentive toward the use of private maternity homes, Treaty Indians were encouraged to use federal hospitals, like the one in Fort Qu'Appelle, where the government would pay for their health care costs. If a Treaty Native were to receive care in a maternity home, that person would have to pick up the cost themselves as the R.M. and the province would not cover the bill. So while treaty hospitals were usually a long distance away, concern over the costs often led treaty Native women to use federal hospitals if they were going to use a hospital at all. Indeed, if a nursing home matron could be sure that she would not get paid for admitting a Native women, then it is likely that they referred such women onto the federal hospitals.

While many people in rural areas of Saskatchewan were immigrants or first generation Canadians, childbirth, to a great extent, seemed to be the cultural leveller:

I don't remember there ever being any language problems and there weren't any Natives around

²⁰⁵Phyllis L. Steele, The Woman Doctor of Balcarres, pg. 26-27. Dr. Steele provided health care for over forty years in this area of Saskatchewan.

Kenaston but there were a lot of central European people, like Ukrainians and Czechoslovakians. In those days they [immigrants] were pretty compliant you know. I don't remember that anybody questioned how they were being cared for or how things were being done.²⁰⁶

Second era homes also did not seem to be exclusively targeted at married or unmarried women. As they were legislated to keep a register of users, the absence of the exclusion of unwed mothers from private maternity homes in the west is the most striking difference from those in the east.²⁰⁷ A number of factors could explain the lack of illegitimate designations. To begin with, the number of single women in western Canada was very low until the Depression years. "Of the 900,000 people who moved west between 1900 and 1911, almost two-thirds were men."²⁰⁸ With marriage practically guaranteed within a short time period, illegitimate births no doubt were not as common as in urban Toronto. In any case, the sheer difference in numbers meant that the woman who found herself pregnant outside of marriage would have greater leverage in demanding marriage from the father of her child. Secondly, if in rural Canada, families

²⁰⁶Muriel Jarvis, Saskatoon, 31 July 1995.

²⁰⁷Reported illegitimate births on the prairies were consistently lower in number than the overall Canadian rate until 1945. George Emery, "Age-Parity and Marital Status Compositional Influences on the Maternal Mortality Rate in Canada, 1930-1969: A Regional Comparison," Social History XXV (November 1992): 242.

²⁰⁸Linda Rasmussen, Loran Rasmussen, Candace Savage and Anne Wheeler, A Harvest Yet To Reap, pg. 13. In the 25 to 34 age group of those in Alberta around 1910, men outnumbered women 8 to 1.

and communities were fairly open in accepting unwed motherhood due to tighter-knit communities, there would be no need to segregate the confinements of unmarried women from married ones.²⁰⁹ Thirdly, it is also possible that women who found themselves pregnant out of wedlock could leave the area for larger urban centres in the United States, eastern Canada or other distant towns and thus conceal their pregnancies in that way:

It wasn't very prevalent in those days or in a small community like that, if a girl became pregnant, she went away some place you know it wasn't like today, usually they'd go off to an aunt or a grandmother, I mean they would just get lost.²¹⁰

In addition, women in isolated locations and those without the funds to spend on formal maternity services continued to give birth with midwives or alone. Illegitimacy could have been hidden from the larger community view by giving birth away from groups of other women but without leaving the immediate area. Lastly, mention of illegitimacy may have been lessened as a consequence of the overall decline in birth and fertility rates outside of Quebec after the turn of the century and up

²⁰⁹ In his study of illegitimacy in nineteenth-century English-Canada, Peter Ward concludes that unwed mothers in rural areas were less likely to leave their communities and conceal their pregnant state while more likely to name the father to authorities. This conclusion points to at least a slightly different concept of illegitimacy in rural areas that is applicable to the highly rural areas of western Canada in a later time period. Peter Ward, "Unwed Motherhood in Nineteenth-Century English-Canada," in the Canadian Historical Association's Historical Papers (1981): 47-48.

²¹⁰ Muriel Jarvis, Saskatoon, 31 July 1995.

until 1937.²¹¹

Women who refused to marry or married after pregnancy was obvious were accepted into maternity homes to deliver but not without an acknowledgment that they had violated some unwritten rule concerning sex outside of marriage. We will not be able to know whether they were treated differently but it is true that maternity home matrons had an opinion on the topic. A woman from Cadillac remembers a point made by her mother-in-law:

I know there were a lot that were just married the right length of time. As far as I know there weren't any single women, usually they'd get married sometime or other. But I remember some talk about big weddings and she'd say 'They should'a been married in her mother's back bedroom with the blinds down.' That was her expression for it, because so often they'd still have a big wedding and then have a baby the next week.²¹²

With the details of maternity home matrons and the people who used the homes established, it now becomes possible to look at the role such homes played in the community and how they reacted to provincial initiatives in health care.

²¹¹Warren Kalbach and Wayne McVey, The Demographic Bases of Canadian Society, second edition (Toronto: McGraw-Hill Ryerson Ltd., 1971), 94-95.

²¹²Mabel Bradley, Saskatoon, 31 July 1995.

Chapter Five

Having detailed the nature of the maternity home operation from both an owner and customer point of reference, it now becomes necessary to contextualize these homes within the larger community and provincial scene.

Figure 4 Nurse Smith's 80th birthday in Kisbey, celebrated in 1956 with women from the community.

While maternity homes were highly visible on the local level, they were, for all purposes, practically invisible at the provincial level.

Most maternity home owners and operators, in addition to providing maternity services to their community, also belonged to local clubs, churches and associations. For example, Mrs. Agnes Reid was a member of the Methodist Church in Carnduff, sang in the choir, played organ during church services, taught Sunday School, and belonged to the Orange Lodge.²¹³ While this sort of participation further solidified the place of nursing home women within a women's space, this contact was

²¹³Carnduff and District History Society, A Stake in the West: Carnduff and District, 1979, pg. 816. Mrs. Reid ran a nursing home from shortly after her marriage in 1910 until the late 1940s.

for other than maternity services and thus increased her local profile overall. Most certainly, because of the male-female segregation of many organizations and clubs, the friendships and alliances made during such activities would increase a matron's clientele for her nursing services:

She belonged to what they called the Social Club and it was a group of women that met, I don't know if they met was it every week or every two weeks, just for a get together. And she always went to the United Church pretty well all the time.²¹⁴

That maternity home nurses had won the respect and power that came with an elderly age and providing community services is obvious.²¹⁵ The nature of maternity work meant that matrons were key to family building and would likely have contact with each family member. This contact, multiplied by a number of families, meant literally that the matrons were the "Mothers of the Community."²¹⁶ Many were celebrated with special teas held in their honour, certificates from the government and one was even crowned Jubilee Queen during

²¹⁴Bessie Hill, Lumsden, 2 August 1995.

²¹⁵Because the nature of maternity work allowed a matron to witness the births of new generations, their service in this area provided the basis for their connection to the community. Dance of the Bridge, pg. 173 summed up a common sentiment in referring to Lottie Meek. "She could always find a place in her clean, comfortable home-type hospital. Her love, concern, devotion and sacrifice touched every family in the district."

²¹⁶This term is used in direct reference to Mrs. Thomas MacNutt of Saltcoats who was a matron there for many years. Saltcoats and District Historical Society, Saltcoats Roots and Branches, 1982, pg. 217.

Saskatchewan's fiftieth anniversary events.²¹⁷ When involved with clubs and community service associations, these women almost always occupied positions of leadership.²¹⁸ In addition, they no doubt inspired several women in the community to go on to nursing careers of their own.²¹⁹ Several matrons had also received recognition for nursing work done elsewhere and this increased their status in the region, as was the case with Mrs. Nye of Conquest, who served overseas during World War I with the Red Cross and won a war medal.²²⁰ While matrons then held power within their occupational realm and in their dealings with women in the community in particular, there is proof that these matrons had power outside of the health care profession as related in this story by Bessie Hill:

I remember one couple and the husband came to see his wife and of course she [Mrs. Inglis] always made tea for anybody that came in the door and she gave this fella and his wife their cup of tea. Well, after he'd gone, his wife started to cry and Aunt Maggie wanted to

217At ninety-seven years of age, Susan Cole of Semans was crowned Jubilee Queen on June 30, 1995 in recognition of her contribution to the surrounding district. Semans and District Historical Society, Always a Hometown: Semans and District History, 1982, pg. 156.

218Annie Willis, as a widow and mother of a young daughter, for example, ran a nursing home for seven years in Ceylon and belonged to the Rebecca Lodge, Homemakers and the Canadian Legion Auxiliary. All were clubs in which she assumed a prominent role. Builders of a Great Land, pg. 47, 110.

219Kathryn McPherson states that in the period 1920-1940, many women who trained in hospitals were of a rural background and "credit(ed) their decision to enter nursing to a local nurse whom they admired". "'The Country is a Stern Nurse'", pg. 185.

220The Conquest Homemakers, This Conquest of Ours, 1904-1948, 1949, pg. 39.

know what was wrong and she said well that's the first cup of tea we've had, that he's had, it was during the Depression and she said if it hadn't of been for their neighbours she said they wouldn't of had anything to eat, hardly, on the table for Christmas. So Aunt Maggie said well why didn't you go, at that time you could get a Relief and she said well, he went down and the guy wouldn't issue him one. Aunt Maggie went to the phone and the head guy got an earful and there was food on the table then when they and the little one went home. So she must have given him a real blast!²²¹

Of course, the status of maternity home matrons eventually changed in nature. Whereas in the past, these women had been highly respected because they offered much needed highly experienced medical help to isolated communities, in later years, they were distinguished for unwavering assistance to the doctor, their advanced age and their overall recognizability to those in their region. The focal point or perception of maternity home matrons and their services changed gradually from one of matron as health pioneer to that of matron as faithful helpmate. To further contextualize the conditions under which maternity homes appeared and then disappeared, a brief history of the development of Saskatchewan's health infrastructure is necessary and will show the transfer of health services "from the individual, to the municipality, later to the region and the province and finally to involvement by the federal

²²¹Bessie Hill, Lumsden, 2 August 1995.

government."²²²

"Without exaggeration it is possible to say that pioneers arriving in Saskatchewan prior to 1900 had virtually no hospital facilities" except the prairie nursing home.²²³ After 1900, the number of hospital facilities other than nursing homes increased rapidly.²²⁴ Despite an increase in number, these hospitals "were overcrowded and unable to accommodate all the sick."²²⁵ By 1920 more than 35 hospitals had been built in the southern area of the province and 23 more were established by 1930.²²⁶ Hospital construction slowed in the Depression years but "the post war injection of provincial funds for hospital construction, health services

²²²Joan Feather and Vincent L. Matthews, "Early Medical Care in Saskatchewan," pg. 41.

²²³Boyd, Angela, Pioneer Health, pg. 2. Boyd claims that nursing homes were "set up on a temporary basis to help cope with community epidemics. A doctor was usually available and perhaps a registered nurse, but most often the service was organized by a self-taught practical nurse who temporarily opened her home to the ill in the spirit of community service. Any attempt to make such services permanent was usually thwarted by the cost of the operation. Income was derived solely from payment by patients who often had very meagre cash resources."

²²⁴Though medical facilities were established, not all of them were open over a long period of time. A maternity home opened in Indian Head in 1895 proves that conditions had to be just right before such a venture could be called successful. Operated by Misses Maud and Mary Crawford under a Dr. John Kemp who specialized in obstetrics, it was shut down shortly after it opened. While population figures probably did not warrant a centralized service at this time and infectious diseases were popularly associated with hospitals, the closure of the home was seen as a failure for private hospitals in particular. "Being an innovation it was not supported to the extent expected. The Crawford Maternity Hospital was born too soon but it blazed the way for public realization that hospital services were needed with public support rather than private enterprise". Indian Head History Society, Indian Head: History of Indian Head and District, 1984, pg. 133.

²²⁵Marquerite E. Robinson, The First Fifty Years, pg. 18-19.

²²⁶Angela Boyd, Pioneer Health, pg. 3-4.

research and hospital insurance"²²⁷ meant there were more hospitals for about the same number of people. For example, the total number of union hospitals in 1944 was 26 but by four years later, the number was up to 78.²²⁸ The history of health care legislation in Saskatchewan should be looked at in more detail. It will become evident that the provincial government gradually came to view health care to be so important that the service became publicly controlled.

The first record of a private maternity home occurs in Regina in 1889. At that time, Regilians voluntarily gave money to the hospital in Medicine Hat, Alberta, but few could afford such a long trip.²²⁹ Mrs. M.E. Truesdell, who had been a teacher, cared for maternity cases, frozen feet and malaria under the supervision of three city doctors and offered a legitimate option for those demanding immediate health care.²³⁰ On occasion, she was paid for her service by the town council, in those situations where patients were obviously town charges. Mrs. Truesdell closed the nursing home in 1897 when the Local Council of Women raised enough money to

²²⁷Ostry, "Prelude to Medicare," pg. 88-89.

²²⁸Ibid., pg. 89.

²²⁹Earl Drake, Regina: The Queen City (Toronto: McClelland and Stewart, Ltd., 1955), pg. 73.

²³⁰The author goes further to say that "to see the need that existed and to find a solution would be the natural reaction of a person with her background, upbringing, and natural talents". Eva Dale, "Mary Erena McKillop Truesdell", vertical file Regina-Hospitals, History of, Prairie History Room, Regina Public Library.

open the city's first public hospital.²³¹

It is widely thought that the great bulk of nursing homes were "set up on a temporary basis to help cope with community epidemics"²³² like the Spanish Influenza epidemic of 1918. While it is true that flu victims needed to be isolated and few hospitals existed to take on all the patients that required quarantine,²³³ it is logical that, in areas where people were concentrated enough to worry about the spread of disease, there was also a critical mass of people that would demand maternity services as well. In addition, epidemics were such that it was not beneficial to group several victims in one place, especially a home where other sorts of treatments were carried out.²³⁴ I would argue then that the influence of epidemics in southern Saskatchewan did not lead to the creation of these private hospitals but brought them to

²³¹Marquerite E. Robinson, The First Fifty Years, pg. 12 and 17. For more information on Mrs. Truesdell, see "Pioneer Hospital in 1899" Regina Leader Post (September 14, 1949), "Early Regina Was Healthy" Regina Leader Post (January 28, 1950), "Private Hospital's first baby still here" Regina Leader Post (September 17, 1955), and "Public Aid developed Hospitals" Regina Leader Post (June 18, 1963).

²³²Angela Boyd, Pioneer Health, pg. 2. While some homes were established to handle epidemics, the success of this type of operation in treating maternity cases meant that they did not just exist on a temporary basis.

²³³Ibid., pg. 67 points out that in 1913, "only 8 of the 23 hospitals in the province provided isolation wards for infectious diseases". This information comes from the Annual Report 1913, Bureau of Public Health, pg. 9.

²³⁴This is not to say that matrons did not assist in the control and treatment of contagious disease. They did and often at great risk to themselves. Miss Marjorie Amy of Saltcoats, for example, contracted the flu in 1918 and died shortly thereafter. Saltcoats Roots and Branches, pg. 220.

public, and male, attention.²³⁵ In addition, if dealing with the spread of disease was the sole objective of these homes, there is no explanation for their existence previous to the first serious epidemic and after vaccinations became popular.

The relationship between doctor and matron, as I have argued, was largely symbiotic. While the longevity of a nursing home and its service area was increased by a doctor's presence, a doctor would not usually stay in an area where no such facility existed. Thus it was that maternity homes actually benefitted from schemes that encouraged doctors to come to and stay in rural locations because "whereas doctors could readily be attracted to the larger urban centers, it was not as easy to attract doctors to isolated villages."²³⁶ The Rural Municipality Act, created in 1916 and amended in 1919, made it possible for municipal boards to collect taxes specifically earmarked to pay a doctor's yearly salary.²³⁷ While not all R.M.s participated in this arrangement, several areas did secure a doctor under the municipal doctor plan and

²³⁵It would seem that if one agrees that the Spanish influenza was brought to Canada by soldiers returning from action in World War I, then a large number of soldiers with the disease would be demanding proper health care upon their return to the prairies. After all, veterans were treated with a great deal of respect and it would only make sense that historians would argue that private hospitals ran by women were established solely on the grounds of addressing the medical needs of soldiers and others infected with the disease, rather than admit that they had existed, depending on population concentration, for over twenty years previously.

²³⁶Heather Meagher, Medicare in Saskatchewan: A Bibliography (Regina: prepared for the Legislative Library in Regina, May 15, 1963), pg. 2.

²³⁷Information on health care legislation comes from Badgley and Wolfe, Doctors' Strike.

their residents enjoyed free consultations with their doctor through payment of their yearly taxes.²³⁸ This plan only covered people seeing their own R.M.'s doctor and meant that medical care had to be delivered in that location. Logically then, hospital care was to be given in the R.M. as well and where union hospitals did not exist, maternity homes picked up the slack. Given the often close ties between doctor and matron, the municipal doctor scheme's tendency to secure one doctor only in a defined area was also usually to the home's benefit. If a doctor whose salary was paid by the R.M. endorsed a certain matron, her business was secure for as long as the doctor remained. Maternity home matrons, in areas where such a scheme was in place, billed their R.M.s just like a doctor did for patients claiming residence in that R.M. In this era then, maternity homes were virtually guaranteed payments for medical care given. The relatively good chance of financial stability meant a great number of homes opened in the era in which municipal doctor plans became popular.

While not directly contributing to the volume of business

²³⁸It should be noted here that not all services were covered in aid received by a doctor whose salary was paid by the R.M. In the high drought areas where the tax base was most eroded, only a certain amount of money was available to pay a doctor. For some unexplained reason, but no doubt largely due to the steady demand for it, maternity work seems to have been subject to a great deal of extra billing with the aim of making up for salary deficits. The actual yearly wage for a doctor seems to be the monitor, that is for salaries under about \$4000, maternity patients are charged an extra fee. For example, Dr. T.H. Argue of Corning received \$4500 a year from his R.M. in 1930 and was not allowed to charge maternity work while in the same year, Dr. Wilken of Warman received \$1500 in salary and was charging \$15 for each maternity case and Dr. Johnstone of Vidora obtained \$1000 in salary and charged \$25 for each maternity case. R 780.1, Department of Public Health (black ledger books of unknown origin), SAB.

done in private maternity homes, the union hospital scheme also did not mean any significant setbacks to the nursing homes' overall viability. As early as 1916, legislative provisions were made for the combining of towns, villages and R.M.s into 'union hospital districts.' In this scheme, several politically distinct areas, with the support of their taxpayers, would pool their money to build a hospital that would then be shared by all contributors. By 1920, there were ten such hospitals and that figure had doubled by 1930.²³⁹ The Depression, though, meant that there was no longer enough money in local council coffers to build new hospitals. R.M.s were lucky if they could manage to keep their doctor paid and constantly fought over responsibility of so-called 'indigents', the expensive ever-increasing hot potato whose medical costs no one wanted to pay. With hospital construction shut down due to a decreasing tax base, private maternity homes continued their operations, largely unfettered by close-at-hand competition.

By 1921, the Department of Health had established detailed regulations under the provisions of the Public Health Act by which maternity homes were required to operate. Maternity homes were explicitly defined by the Department as "a private home or hospital for the reception and care of

²³⁹Badgley and Wolfe, Doctors' Strike, pg. 10.

patients in or in respect of childbirth."²⁴⁰ This legislation made it possible for the Department to inspect such a place and its records at any time and a letter to the Department detailing such criteria as the qualifications of the matron, bed capacity and rates for accommodation was accepted as an application for license. The regulations also make it very clear that, in spite of the lack of doctors, "a qualified medical practitioner" should be in attendance for all cases. In addition, "a thoroughly trained or qualified nurse shall be in charge as the person responsible for the conduct of the institution and care of all patients under the direction of the medical men."²⁴¹

The first evidence that the provincial Department of Health would actually attempt to begin regulating maternity homes through their community comes in 1925. In the Annual Report of the Department of Public Health for that year, the department claimed to have:

four district sanitary officers who during the year visit every town, village and hamlet and confer with the local health authorities, advising them of their responsibility in protecting the health of the community.²⁴²

²⁴⁰The category of 'maternity home' overlaps the 1921 definition of a 'private hospital' as "a house in which two or more patients are received and lodged at the same time other than a hospital or other establishment receiving government aid." "Regulations re Private Hospitals, Maternity Homes, Rescue Homes, etc.," The Saskatchewan Gazette Volume 17, No. 4, 1921.

²⁴¹Ibid.

²⁴²Miscellaneous correspondence, "Regional Health Services," R194.2, File 70, SAB.

While in the areas that had doctors and/or hospitals, the 'local health authorities' would be easily determined and obvious, in smaller towns, the local nursing home was inspected and the matron required to participate in a discussion about the risks of infection, etc. Because so few 'sanitary officers' covered such a wide area, it would be quite rare to get a visit from one. No doubt the possibility lessened the feelings of autonomy maternity home operators felt they had from government regulation.

The next development, in 1929, was more thorough in its scope. Each settled area received the following letter to be filled out and returned:

Form from the Department of Public Health.
Required from each Village, Town, City and
Rural Municipality - return to department

Are there any Private Hospitals or Maternity
Homes in your Municipality? If so, please
give following particulars-
Private hospital located at _____
Person in Charge _____²⁴³

These forms, completed by the area's officials, often 'turned in' women who wished to remain distant from any sort of government regulations and just continue on as they had for many years.²⁴⁴ Some matrons expressed surprise when sent

²⁴³Form found in black ledger books, R780.1, Department of Public Health, SAB

²⁴⁴Towns also began to question the qualifications of the nursing home matron in later years and rather than responding to governmental inquiries, made queries of their own. The secretary-treasurer of the village of Hudson Bay Junction, for example, wrote the Deputy Minister of Health questioning whether or not Mrs. Annie Turcotte's home was required to have a registered nurse and if the village may "close the above nursing home if a nurse is not kept." Mrs. Turcotte was at that time a licensed

forms detailing maternity operations by the government and attempted to deny that they were running an establishment that needed to be licensed or regulated in any way:

I do not claim to be running a maternity home.
I was only taking care of those who were
unable to be taken care of at home and were
not able to go to hospital.²⁴⁵

The latter years of the Depression spelled the beginning of the end for private maternity homes in southern Saskatchewan. Up until that point, maternity home matrons had managed to adapt to political changes that affected them while building status within the community and remaining relatively autonomous from political bodies. While nursing home matrons had taken food and supplies in lieu of cash for their services during the lean years, there came a point when most maternity matrons, both in areas with and without a health plan, felt it necessary to their families' survival to approach their local rural municipality for assistance in collecting unpaid fees, both from indigents and, in areas where no medical plan existed, resident customers. In hindsight, it seems that the R.M.s established the goal of eventually taking over the complete administration of hospital care immediately after assuming responsibility for uncollectible accounts from both

maternity home operator. Letter of February 11, 1939, GS 64, PH 5, File 41, Department of Public Health-Nursing Division, SAB.

²⁴⁵Mrs. E.H. Gillespie of Landis describes here the exact rationale behind the demand for nursing homes in this area. In operation for almost four years, Mrs. Gillespie charged \$2 per day and admitted primarily maternity cases. "Application Form for License(January 20, 1939)," GS 64, PH 5, File 42, Department of Public Health-Nursing Division, SAB.

doctors and maternity homes in the 1930s. I would argue that R.M.s took on the liability for unpaid medical bills for both indigents and resident ratepayers in an attempt to encourage the continued service provided by maternity home matrons until such a time as the R.M. had a sufficient tax base to afford to completely administer health care through their own political means. Surely there can be no other explanation for the R.M.'s willingness to take on an increased debt load in a time of financial hardship other than out of respect for the efficient services provided by these women and their ability to do so at a low cost.

The passing of the Mutual Medical and Hospital Benefit Association Act in 1938²⁴⁶ further contributed to the demise of nursing homes in southern Saskatchewan. Private health insurance, backed by both doctors and investors at large and promoted to individuals rather than councils, meant that holders could go to any hospital and see any doctor they wished, with some exceptions. In addition to undermining local municipal doctor and union hospital schemes, the coverage under these plans meant there was no reason to patronize a local cottage hospital and business began to fall off. The close relationships between doctor and matron also deteriorated as increased numbers of new doctors, responding to demand created by this private health insurance, became involved in delivering medical aid in areas where

²⁴⁶Bailey and Wolfe, Doctors' Strike, pg. 16.

traditionally a steady flow of patients had been brought in to a home by one long-familiar doctor's endorsement. These new doctors reduced the status of any long-term resident physician and would seldom recommend one of their policy holders receive treatment in a home instead of a hospital.

The Second World War and its demand for doctors also played a role, somewhat ironically, in the gradual disappearance of privately run maternity homes. While one might suspect that a decrease in the number of doctors in southern Saskatchewan would lead to a resurgence in the number of maternity homes and the power of matrons to conduct births and other procedures without a doctor's assistance as it did in the first twenty years of the province's history, in fact the opposite is true. While the infrastructure that demanded doctors always be present in administering medical care grew, the decreasing number of doctors meant the end to a number of homes. While the war drew large numbers of younger doctors, both the traditional, old-style doctor and his partner the maternity matron were getting on in years and the bulk of such partnerships across the region were often retired. The matron would retire when a young doctor signed up (because the matron would have no supervising doctor which by then was definitely required in all cases) or after the end of the war, when several new hospitals were built and young doctors seeking

positions and practices back home²⁴⁷ forced the elderly doctor to retire.²⁴⁸

The solidification of the nursing profession that began with their governmental responsibilities through Public Health continued during the war years and contributed to the perceived old-fashionedness of maternity homes. Practical nurses, as most matrons were, no matter what level of experience they may have had, were not recruited for overseas service. Many younger single maternity home matrons with formal training became military nurses.²⁴⁹ Thelma Wilson, R.N. of Loverna, for example, immediately closed down her nursing home and joined the Air Force in World War II.²⁵⁰ While the immediate lack of nurses on the home front created by the war meant that practical nurses could legitimately

247From 1949 to 1962, for example, the population of the province increased by 11% while the number of doctors increased by 43%. Aleck Ostry, "Prelude to Medicare," pg. 101. This influx of physicians contributed to the retirement of many a country doctor and matron.

248"In March of 1943, there were 311 general practitioners in the province or one for every 2882 people. Of these, almost one-third were over sixty years of age. Outside of the eight cities, there were 213 general practitioners or one for every 3471 persons. A minimum adequate standard is one (doctor) for every 2000. Saskatchewan thus needs about 140 additional general practitioners, plus about 75 to replace the men who are waiting for the end of the war to retire." The Department of Public Health, "Report on Regional Health Services: A Proposed Plan", Section IV - Personnel and Facilities, HSPC, February 15, 1945. R-194 GR 39-1 File 65, Department of Public Health, SAB.

249In addition to matrons signing up for war nursing duties, maternity homes that had secured the services of a nurse during the Depression lost those employees in the early 1940s. Lottie Meek of Abernethy, for example, explained to the Department of Health that she "has not, at the moment, a graduate nurse in my employ, my nurse being in the R.C.A.F." Letter of January 15, 1944 attached to "Department of Public Health Private Hospital or Nursing Home Annual Report 1943", GS 64, PH 5, File 42, "Department of Public Health-Nursing Division", SAB.

250Loverna New Horizon, Borderline Memories, 1980, pg. 114.

carry on²⁵¹ while the war was in progress, the end of the war meant a dramatic increase in the supply of nurses. Training hospitals had increased their class sizes to supply nursing staff for the war effort and a greater number of women were attracted to the profession because of its increased prestige and opportunity for occupational acknowledgment. By 1945, the supply of nurses outstripped a demand that would only slowly be absorbed during the period of massive hospital construction in the post-war years. The international recognition Canadian nurses received in their war work overseas so standardized the profession and the academic rigour of nursing that literally nothing less than fully hospital-trained nurses were acceptable. Practical nurses of the old tradition had no place in such a climate and carried less power because of the inevitable comparison with formally trained nurses.

When it became clear that a new standard of educational background was expected, some women took measures to protect their by-now almost obsolete careers in the changing times of the post-World War II era. The government consented to allow practical nurses to obtain their 'papers' if they completed a

²⁵¹While this was true for rural areas, practical nurses were undergoing considerable persecution in urban areas. Miss Crawford's nursing home in Saskatoon came under scrutiny when her only graduate nurse suddenly left. The Director of Nursing Services warned her that "this, of course, cannot be permitted to continue." The correspondence that followed seems to have largely been the result of the views of a Dr. Wilson, who did "not wish Nursing Homes in Saskatoon approved for permits unless they have a fully trained person in charge." Letter from the Director of Nursing Services to Mrs. H.C. Wilson on April 5, 1939 and to Miss M.M. Berry on May 30, 1939. GS 64, Ph 5, File 41, Department of Health-Public Nursing Division, SAB.

one year course in Winnipeg. For most women, perhaps short on money with familial commitments that would not allow them to leave the province for a year, perhaps at an advanced age²⁵² and not having had much schooling of any kind, this governmental offer meant nothing. Some lobbied for a nursing permit based on quantity of experience. This would have meant that nursing home matrons would, in most cases, qualify as full nurses according to the Department of Health. These permits never materialized. The advent of courses for nursing assistants, their low wages for a great portion of unskilled work and their resulting popularity were the final straw for nursing home matrons.²⁵³

Just before the war ended, a revised set of regulations were put in place concerning maternity homes. The term 'nursing home' became the term of choice and covered "an institution or house with two or more beds where patients or persons are received, lodged, boarded or retained for care or treatment for which a charge is made."²⁵⁴ The term was meant to include both maternity homes and private hospitals and each

²⁵²Applicants to most nursing schools had to be between nineteen and thirty or thirty-five years of age which meant that women who had been operating maternity homes would have exceeded the age limit. Kathryn McPherson, "'The Country is a Stern Nurse'", pg. 180.

²⁵³The increasing emphasis on nursing assistants and the move away from practical nurses is apparent in the Department of Health discussions on the topic. R-999, #9A, "Nursing Aids, Practical Nurses, 1952-1965", SAB.

²⁵⁴"Regulations Relating to Nursing Homes," The Saskatchewan Gazette, Volume 40, April 8, 1944, pg. 37. Why the government decided to change their use of the term is unknown.

home was to be inspected before a license to operate was given. Demand for detailed records of all procedures was increased, most notably in a new insistence for information surrounding any abortion-type procedures.²⁵⁵ Penalties for operating a nursing home without permission from the Department included a summary conviction that carried a fifty dollar fine or six months in jail.²⁵⁶

What new legislative developments envisioned by the CCF and established by 1947 meant in essence was that health care was further formalized and benefits were no longer tied to a specific rural municipality or doctor. After 1944, medicare travelled with the holder, who was no longer required to stay in one geographical place to receive medical aid free of charge. Only the availability of transportation and its cost, along with the conditions of roadways, limited a person who wanted to get treatment in a large city centre in their own R.M. In the post-war period of prosperity where more families owned cars and road conditions were greatly improved by an increased tax base, the challenges of leaving an area were

²⁵⁵The mention of abortion procedures in the 1944 Regulations is conspicuous because the 1921 Regulations do not discuss such matters at all. The more recent regulations demand that "where a patient is admitted to a nursing home in the condition of abortion, or threatening abortion, or where therapeutic abortion is indicated or wherever emptying of the uterus is indicated for whatever reason, except in the case of an emergency, two duly qualified medical practitioners shall examine the patient...before any operative interference is carried out." Perhaps as part of the new preoccupation with state health care, government administrators assumed that private nursing homes motivated by profit were performing illegal abortions. Ibid., pg. 38.

²⁵⁶Ibid., pg. 39.

insignificant enough to mean that maternity homes could not compete with big city hospitals. In addition, the provincial government was more rigorous in checking bills sent forward by private hospital matrons than the R.M.s had ever been, perhaps because these women were known in their home communities and not at a provincial level. By this time, only provincially recognized homes, that is those with a license, were operating. It did not make financial sense that patients who had medical coverage would employ a matron who would have to charge them directly because, without a licence, she did not qualify for reimbursement. To arrange for payments from the hospitalization fund, the nursing home had to hold a permit to operate, have an attending physician to sign admission and discharge forms and submit details of any patient who required an abnormally long stay.²⁵⁷ While rates of payment were quickly set for maternity homes, documents from that era suggest that the role private homes played in provincial health care would be small and then decrease all together. The female name at the top of a claim sent to the Department of Health would automatically signify a private hospital. The Department preferred to deal with doctors rather than matrons and applied continuous pressure to phase out private nursing homes completely.

²⁵⁷From a letter to all nursing home matrons from F.D. Mott, HSPC in December of 1946. The same letter detailed the rates payable in each case as well. GS 64, PH 5, File 41, Department of Public Health-Nursing Division, SAB.

The rates of payment issue exerted the most negative administrative influence over those who were attempting to continue in the nursing home business. The Hospital Services Planning Commission quickly endeavoured to set standard rates of reimbursement to those operating nursing homes in the province based on the inspection reports of the public health nurses and the annual applications for private hospital licenses. Health care facilities were separated into three groups, membership in which was determined primarily by the number of beds available. They were then given a certain 'point' designation (more points meaning a more modern facility)²⁵⁸ that would then be used to ascertain the rate of payment. Such a system was problematic, largely because operating costs varied depending on a number of external factors such as geographic location. The Chairman of the Health Services Planning Commission, Dr. F.D. Mott, recognized soon after that incongruities were arising from this system:

While most hospitals in Saskatchewan have been able to meet their costs of operation, a number of institutions, for the most part those with less than 25 beds, have experienced financial difficulties. In order to help hospitals suffering hardships because of the difference in payments made to them and their actual cost of operation, the HSPC decided to make up a portion of hospital deficits...applicable only to 1947 costs and

258As of October 1947, for example, the Regina General Hospital was a 814 point facility, whereas the nursing home in Radville was a 529 point facility. Higher points meant a larger payment per day per patient because of the assumed higher overhead costs. "Rates of Payment from the Saskatchewan Hospitalisation Fund for the months of September and October, 1947", R326 File 62, Department of Public Health, SAB.

payments.²⁵⁹

Determining what amount of any incurred deficit would be paid by the province allowed government officials to further pressure maternity homes out of the health care business because they demanded access to all records and insisted that all "institutions must be efficiently operated and must provide adequate standards of care."²⁶⁰ By 1947, and despite the fact that a good proportion of the health care bureaucracy had been born in private maternity homes, the standards and definitions of adequacy and efficiency had changed to a point where nursing homes no longer met the criteria.²⁶¹ In any case, the rates of payment were not significantly higher than matrons had been charging since the 1920s, though they were adjusted in ten day increments, the time the average maternity patient would stay in a home.²⁶² This system of grouping

²⁵⁹From a letter to All Hospitals and Approved Nursing Homes from F.D. Mott of the HSPC, October 29, 1947. R326, File 62, Department of Public Health, SAB.

²⁶⁰Ibid.

²⁶¹R.M. of Norton History Committee, From the Roughbank to the Buttes: R.M. of Norton, No. 69, Villages of Amulet, Forward, Khedive, Moreland and Pangman, 1981, pg. 26. This local history book is one of the few to make the connection between hospitalization and the end of nursing homes. It states "This was the end of nursing homes, and the doom, as it were, of the practical nurses. Hospitals required R.N.'s. Government regulations had to be observed."

²⁶²From a list of approved nursing homes ranging from 497 to 657 points, the average rate for the first ten days (at rate of 6.5 mills) was 3.66, 3.38 for the second ten days (at rate of 6 mills) and 3.10 thereafter (at a rate of 5.5 mills). "Rates of payment from the Saskatchewan Hospitalization Fund for the month of March, 1947" R326 File 62, Department of Public Health, SAB. This translates into an average rate of payment not much different from the forty years previous. From a January 1947 list of 43 approved nursing homes, the average rate payable was \$2.14 per day for adults and children. Fifty cents was payable for newborns though that was eventually increased to \$1.00. "Nursing Homes

hospitals according to bed capacity for purposes of rate setting and determining the contribution to any operating deficits was discontinued in 1949.²⁶³

The debates on the rate of payments to private nursing homes offering private and semi-private beds gives further insight into the government attitude toward the homes. A circular from July of 1947 reported that the SHIP would cover increased charges for private beds in all of Saskatchewan's hospitals. Through this regulation, matrons could charge the government for private accommodation in a public ward that contained only one person or for a room that could only contain at most one person due to the construction of the home, thereby receiving additional revenue. However, this circular was not sent to nursing homes because officials assumed that this news would encourage them "to make extra charges to beneficiaries in the remaining 40% of the beds." So while the ruling to pay for private wards affected only smaller hospitals and nursing homes which would have a greater proportion of single rooms and a smaller clientele at any given time, the matrons were not made aware of it. F.D. Mott felt that "because of the limited facilities provided by these very small homes, that no extra charge should be made to the beneficiary, even though he may be the only patient in his

Operating Under Permits."

²⁶³Ibid. From a letter to All Public Hospitals and Nursing Homes from F.D. Mott, HSPC, and H.E. Baird, Saskatchewan Hospital Association, December 30, 1948, pg. 2.

particular room" and asked that news releases on this issue use the term "nursing home" only rather than "approved nursing home" or "nursing homes operating under permit."²⁶⁴ Had the homes known about this regulation, they could have legally applied for a greater payment than they would have otherwise and increased their profitability. This was part of the overall move to phase out the homes by a less than straightforward means.

While the cost to patients was the same no matter where they went, maternity homes received less payment for the same services as more modern hospitals. With the province's attention firmly fixed on health care issues and the popular post-war obsession with new and modern, scientifically up-to-date medicine, nursing homes were no longer popularly seen as the best medical care option and patients headed to urban centers to have their babies and for other procedures. Matrons quite simply could not compete on a long-term basis with the new hospitals, not in perceived capability to deliver quality health care and not against the new fascination with technology.²⁶⁵

For women who had previously worked alone or in co-

²⁶⁴From a letter to G.W. Meyers, Executive Director, SHSP, from F.D. Mott, HSPC of July 28, 1947. R326, File 62, Department of Public Health, SAB.

²⁶⁵Maternity homes, of course, could not even attempt to buy new medical equipment like x-ray machines and incubators, even with adjusted rates of payment, as the overhead cost of such items would not be considered by the province. As well, most matrons would not have had the money necessary for even a down payment on such items.

ordination with their town councils or rural municipalities, dealing with the province on health care matters meant a constant barrage of paper work and regulations. While nursing homes had always kept records in the early years for the purposes of billing their patients directly and had been responsible for completing birth registries, the provincial government demanded that additional records be kept for their files as well, especially after matrons began billing the government instead of their patients. It was made clear that, in addition to purposes of payment, forms were filled out so that the government could monitor the operations of maternity homes which had for so long not answered to the Department of Health. In requesting the use of new patient discharge forms, G.E. Wride, Acting Director of Hospital Planning and Administration, stated that the forms were designed "having in mind the almost complete lack of record available for statistics in the majority of private nursing homes under permit."²⁶⁶ With applications for license, birth records, personal files, doctor's records, and billing packages all required by the province, nursing home owners had more paperwork than ever before.

For those who had been in operation for a long time, such

²⁶⁶From a sample letter to Dear Madam from G.E. Wride on June 19, 1948. This form was required in order for provincial billing and was to be filled out for each patient leaving the home. The form is one page (with seven pages of instructions) and asks for details on procedures preformed, largely those related to maternity cases. All forms were to be forwarded to the Department of Health. "Supplemental Discharge Form Required of Private Nursing Homes Under Permit." R326, File 59, Department of Public Health, SAB.

requirements must have been annoying. Records had, in the past, been of a very personal nature and, in keeping with the traditional respect for privacy, were not to be seen by anyone but the matron herself. This fact made this research more difficult as many women burned their records in later years. Mabel Bradley lived with her mother-in-law in the Cadillac Nursing Home and explains:

I'm sure she never got paid for a lot of them. We were always disappointed that she destroyed all her records. She figured it was nobody's business but hers. But I can remember, oh we hadn't been married too long, and they had a piano in the front room and a piano bench and I was dusting or doing something in there and opened the bench to see what was in it, what music was in it. Well here was this record book of her cases. Anyway, she came along and saw me and oh her face! Those were her records and it was nobody's business! She had to keep those records for the government and [when she moved into the old folks' home in Moose Jaw], she destroyed all these records and pictures, too.²⁶⁷

This issue of records and of the need to answer to an external authority provided the impetus for several matrons to leave the profession altogether:

She quit in 1948 or 1949, I think, you see there was so much red tape then, she had to fill out so many papers and she says 'ugh!' She knew what to do (in maternity cases) and that was it and once the government started giving out papers to fill out, well she didn't want anything more to do with it.²⁶⁸

The government interference resulting from the

²⁶⁷Mabel Bradley, Saskatoon, 31 July 1995.

²⁶⁸Anonymous subject, interview by author, tape recording, Strasbourg, 1 August 1995.

introduction of socialized health care came with a price for maternity matrons and the Department of Health was not subtle concerning their ultimate goal:

We recognize the value of the contribution that has been made in the past by nursing homes. At the same time we are sure you will realize that the demand for completely modern hospital care means that this type of service will gradually be substituted for that now being provided by nursing homes.²⁶⁹

A small number of nursing homes remained open past 1947 and 1948. Those that did were largely in more isolated areas where hospital construction was of a lower priority.²⁷⁰ In the post-war years, there was a massive move of rural residents to urban areas,²⁷¹ the migration and the newly-modernizing hospitals in those urban centers limiting the pool of consumers that had previously been served by nursing homes. In addition, it almost immediately became necessary to take federal funds for health care programs, funds which of course had to be spent in a way acceptable to the federal government. Only a handful of homes remained for more than a couple of years past this point. Mrs. Alice Monkhouse in Avonlea closed her home in 1957, after almost twenty years of service and the

²⁶⁹From a letter to All Nursing Homes from F.D. Mott, HSPC, July 15, 1947. R326, File 62, Department of Public Health, SAB.

²⁷⁰Duane Mombourquette claims that so efficient was the Health Services Planning Commission that most of the CCF's health care goals had been put into action. "An Inalienable Right: The CCF and Rapid Health Care Reform, 1944-1948," Saskatchewan History 43, No. 3 (1991), pg. 101-115.

²⁷¹John Archer, Saskatchewan: A History, pg. 297.

birth of over 900 babies.²⁷² Likewise, Mrs. Tom Reid, operating in Carnduff since 1919 and averaging over 40 babies a year, closed in 1954, the year after the hospital was built.²⁷³ These two women appear to be the last of a long tradition of maternity home operators in southern Saskatchewan.

Hospitalization effectively eliminated the 'middle-woman' nature of health care created by provincial legislation after 1916. Rather than make use of maternity homes, the province finally decided to collect the money, and build, staff, and run the hospitals itself, cutting out any role that matrons had played in the past in delivering care and billing patients directly or through whatever body held a plan in their patients' place of residence. Like the position maternity homes occupied between home and hospital births, their historic administrative role between their patients and a political body had been further erased with the move toward public controlled modern health care.

Maternity home matrons rarely made the transition into public hospitals; for the most part, when their homes shut down for business, they retired from nursing. In fact, so definite was the break with the tradition of nursing homes that most matrons gave any useful supplies they had to the new

²⁷²Arrowheads to Wheatfields, pg. 65.

²⁷³The Jubilee Committee, This Way Homesteader: Carnduff, 1904-1955, 1955, n.p.

public hospital.²⁷⁴ In the few cases where experienced-trained matrons did get employment in a hospital, they were not working as nurses. Mable Hultien, after operating a nursing home in Midale for almost ten years became the cook at the new Union Hospital when it opened in 1949.²⁷⁵ If the community got a hospital in the early 1940s, a maternity matron who was a graduate nurse had a better chance of employment. Miss Margareth Berg, R.N. of Hepburn was, for instance, hired as the first registered nurse to work in the new hospital, which opened in 1936.²⁷⁶ Ironically, nursing homes were thought to be so old-fashioned that the term was appropriated for a relatively new invention that involved the retirement years of most of the matrons - the term nursing home came to mean an extended care facility for the elderly and was synonymous with the 'old ways' by being the antithesis of contemporary ideas.

²⁷⁴Mrs. Amblin, for example, donated linens, medical equipment and \$750 in bonds to the new Quill Lake Union Hospital and shut her business down. Quill Lake Historical Society, With Quill in Hand: Quill Lake and District, 1903-1983, 1984, pg. 174.

²⁷⁵Plowshares to Pumpjacks, pg. 71.

²⁷⁶Hepburn History Book Committee, Our Rich Heritage: Hepburn and District, 1994, pg. 57.

Chapter Six - Conclusion

Whether or not women in this era were consciously attempting to stall the transition of birth from home to hospital by establishing first and second era maternity homes is unclear but not probable. The concerns in eastern Canada during industrialization there, while generally conservative in tone, did not demand that all women take control of their reproductive process. The imposition of class interests overpowered any level of true maternal feminist concerns, as the middle and upper classes took control of a crucial part of the lower classes' reproduction. Indeed by giving birth outside of marriage, the lower classes were seen to have willingly given their 'social superiors' control in determining where and with whom childbirth would take place. The middle and upper classes, able to afford to give birth under locational and technological conditions of their choosing, did have control over their own birth experiences. In that sense then, first era public maternity homes can be viewed as a symbol of class oppression in developing Canada. Nowhere is this seen more clearly than in the legislative pressure on these homes, that while making a profit, shared a common class consciousness with the women using them and were not formally mandated to pass judgment on unwed mothers. By actively recruiting lower class women, judging them as 'fallen' and

hiding them in predominantly religious homes where they could do penance for their sins, middle and upper class women in charitable organizations did not address class disparities but attempted to exert a patronizing power over those less fortunate than themselves.

Private maternity homes in western Canada in later years, while also acting to fill a vacuum in the necessary health services, were operated with a different tone. These homes did not make distinctions between legitimate and illegitimate parturition as a condition of entry and began to disappear not under legislative pressure promoted by organized charity but by that of organized state medicine. The move to further medicalize birth by using economic subsidies in order to encourage physician attended childbirth in hospitals effectively removed the need for maternity homes. Second era maternity homes were able to stall the process of complete medicalization, partly because of specific factors resulting from the regional disparities of industrialization and because women on the prairies were consciously building communities with members that needed care during childbirth. These second era maternity homes of western Canada provided a great service to women giving birth. Not subjected to outright moral judgments and not generally excluded on racial or religious criteria, women in these homes could request the application of scientific technologies, be attended by midwives, nurses or doctors and come in contact with other women. In addition,

the homes were going business concerns and meant that all involved were at benefit, including customers, matrons and doctors. The similarities between these second era private maternity homes and today's birthing centres are clear. With continued cutbacks on health care spending in this post-industrial age, birthing centres could become virtual replicas of prairie maternity homes by coming under private ownership and operating for profit.

Appendix 1

Map of Southern Saskatchewan

Appendix 2

Letter to the Editor

To the Editor:

I'm seeking information from your readership. In order to complete my Masters degree at Carleton University, I'm currently doing research on the history of prairie maternity homes from roughly 1920 up to the early post-World War II years. Of great interest to me are privately owned and operated homes in both rural and urban settings in southern Saskatchewan, particularly any in the town of Maple Creek and area. If any of your readers have any information on maternity homes of this type - their geographic location, the way in which they were operated or any old photographs, for example - I would appreciate their help on this project. In addition, women who owned or worked in a home, had a child in one and those who were born in such a facility are invited to share their experiences. Readers can contact me at the address below and I would appreciate it if they would include their mailing address and phone numbers so I can get in touch with them during the summer of 1995.

Appendix 2

List of Participants and Sample Release/Consent Form

Lists of Participants

All research subjects were interviewed in 1995.

Anonymous Subject	July 19	Quill Lake, SK.
Hazeldene Evans	July 23	Carlyle, SK.
Marie Raynard	July 23	Kenosee Lake, SK.
Della Robertson	July 24	Carlyle, SK.
Edna Anderson	July 25	Estevan, SK.
Gladys Hanson	July 26	Weyburn, SK.
Pearl Rainey	July 26	Pangman, SK.
Lillian Helland	July 26	Assiniboia, SK.
The C. Shoemakers	July 26	Mossbank, SK.
Muriel Jarvis	July 31	Saskatoon, SK.
Mable Bradley	July 31	Saskatoon, SK.
Anonymous Subject	August 1	Strasbourg, SK.
Alvina Kelln	August 1	Duval, SK.
Bessie Hill	August 2	Lumsden, SK.
Dollina Childs	August 2	Lumsden, SK.
Frances Gaber	August 2	Cupar, SK.
Hazel Foster	August 3	Abernathy, SK.
Lynn Brady	August 3	Carlyle, SK.
Adeline Brady	August 3	Carlyle, SK.
Ethel O'Neill	August 4	Carlyle, SK.
The H. Browns	August 4	Carlyle, SK.
Alma Miller	August 5	Carlyle, SK.
Loretta Brady	August 7	Carlyle, SK.
Laurel Valentine	August 21	Rocky Mtn. House, AB.
Penny Hansen	August 29	Red Deer, AB.
Mary G. White	August 30	Rocky Mtn. House, AB.

Release/Consent Form

This release/consent form is necessary in order to obtain the research subject's permission for the information discovered in an interview to be used in the interviewer's written work. Please be advised that you are not required to answer any questions you do not wish to and that this research is being undertaken as part of the requirements for a graduate degree from the School of Canadian Studies at Carleton University. If you do not wish your name to appear in the final draft of this study, please inform the interviewer.

In providing information on the topic of maternity homes
in southern Saskatchewan from 1930 to 1945, I

_____ hereby grant permission to
Laurel Halladay to use the transcript of our tape recorded
conversation in the following ways:

_____ in her thesis

_____ in published articles and manuscripts

Interviewer
Laurel Halladay

Research
Subject

Appendix 4

Letter to the Research Participants

"Maternity Homes in Southern Saskatchewan, 1930-45"

To the participant:

Thank you for participating in this study of maternity homes in southern Saskatchewan, 1930-45. As a research subject, you will be asked for information on your experience of such homes in terms of their operation and any effects the service had on the delivery event. In addition, depending on the way in which you define this experience, you will be asked to answer questions concerning the religious, ethnic, political, educational, marital and age background of yourself or of those family members to whom you are referring.

This release/consent form is necessary in order to obtain the research subject's permission for the information discovered in an interview to be used in the interviewer's written work. This study has received ethics clearance through the School of Canadian Studies at Carleton University. Please be advised that you are not required to answer any questions you do not wish to and that this research is being undertaken as part of the requirements for a graduate degree from the School of Canadian Studies. If you do not wish your name to appear in the final draft of this study, please inform the interviewer and in that case, confidentiality can be assured. Any further concerns about this study may be addressed to the researcher at the address below or to the Canadian Studies Graduate Supervisor Katherine Arnup at (613) 788-2366.

Appendix 5

Bibliography of Local Histories

All the following local history books are available at the Prairie History Room in the Regina Public Library. They are listed alphabetically by town of publication and while not all are cited in the text, all have been used to gain a greater understanding of the biographical context of these entrepreneurial women's lives and also to explore the historical treatment such women have received from their own communities.

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Admiral History Book Club, Admiral: Prairie to Wheatfields, 1978.

Alameda and District Historical Society, From Dream to Reality, 1982.

Alameda History Committee, A History of Alameda and District, 1905-1955, 1955.

Aneroid History Book Committee, Aneroid: The Rising Barometer, 1905-1980, 1980.

Antler and District History Committee, Footprints in the Sands of Time, 1983.

Asquith and District Historical Society, The Asquith Record, 1982.

Arcola-Kisbey History Book Committee, Arcola-Kisbey Golden Heritage: Mountain Hills to Prairie Flats, 1987.

Assiniboia Golden Jubilee Committee, Golden Memories, 1955.

Assiniboia History Committee, Heritage '85: The Town of Assiniboia, 1985.

Avonlea Historical Committee, Arrowheads to Wheatfields: Avonlea, Hearne and District, 1983.

Balcarres History Book Committee, Furrows in Time: A History of Balcarres and District, 1987.

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Centennial History Committee, Proud Heritage: Conquest, Saskatchewan, 1968.

Coronach History Committee, From the Turning of the Sod, 1980.

Cupar Historical Committee, Cupar and District: Taking Root...and Growing, 1981.

East Cut Knife and Districts Historical Society, Where the Cut Knife Waters Flow, 1980.

Delisle Book Committee (Women's Institute), Through the Years: Delisle and Donavon, 1973.

Dinsmore Historical Committee, Dynamic Dinsmore, 1979.

Eastend History Society, Range Riders and Sodbusters, 1984.

Elrose and District History Book Committee, Prairie To Wheatfields, 1985.

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Estevan Collegiate Institute, Fifty Years With PWOCO: A History of the Community of Estevan from 1892 to 1955, 1955.

Fife Lake History Book Committee, Gathering of Memories: Fife Lake, Constance, Little Woody and Area, 1981.

Foam Lake Historical Society, They Came From Many Lands: A History of Foam Lake and Area, 1985.

Frontier History Book Committee, They Blazed, We Followed, Volumes 1 and 2, 1993.

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Highworth Book Committee, Prairie Wool and Pussy Willows, 1982.

Indian Head Historical Committee, Indian Head: History of Indian Head and District, 1984.

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Appendix 6

Two Licenses Issued to Maternity Homes by the Department of Public Health

GOVERNMENT OF THE PROVINCE OF SASKATCHEWAN
DEPARTMENT OF PUBLIC HEALTH

CANADA:
PROVINCE OF SASKATCHEWAN
TO WIT:

LICENSE TO CONDUCT A Nursing Home

 NO. 1212

This is to certify that Miss Scott
 of Cupar, Saskatchewan, is hereby authorized under the provisions of
 The Public Health Act to conduct a Nursing Home
 at premises situated at Cupar, Saskatchewan, for the year
 ending December 31st, 1931
 Inspected Feb. 3, 1931
 Dated at Regina this 3rd day of March 1931

L. C. Middleton
Deputy Minister

GOVERNMENT OF THE PROVINCE OF SASKATCHEWAN
DEPARTMENT OF PUBLIC HEALTH

PERMIT TO CONDUCT Nursing Home

This is to certify that Mrs. W. H. Harkness
 of Fife Lake, Saskatchewan, is hereby authorized
 under the provisions of Regulations issued under The Public Health Act to conduct a
Nursing Home
 at premises situated at Fife Lake, Saskatchewan, for the year
 ending December 31st, 1940.
 Inspected May 15, 1940.
 Dated at Regina this Twenty-first day of May 1940.

R. B. Baring
Deputy Minister
per M. M. M.

116-5-40

Appendix 7

Attendant at Birth and Infant Death at Birth as a Percentage of Attendants' Cases, 1915 - 1950²⁷⁷

The table below shows that before 1940, babies had a higher chance of living if born with a nurse or with neither a nurse or physician. While the higher infant mortality associated with doctors may be due to the tendency for people to wait until they were in a crisis situation before they called the doctor, the higher percentage can also no doubt be attributed to technical problems (like misuse of equipment and drugs) and circumstances related to hospitals (like infections).

	Physician	Nurse	Neither
1915	10855(1.69)	1091(0.18)	5582(0.38)
1916	12000(1.93)	593(0.34)	6650(0.92)
1917	13251(2.09)	597(0.50)	6828(0.95)
1918	13929(2.62)	637(----)	7120(0.88)
1919	13756(1.83)	635(----)	6568(0.99)
1920	15433(2.34)	401(0.25)	7430(0.81)
1921	15268(2.31)	220(----)	7492(0.36)
1922	15001(1.99)	182(----)	7632(0.90)
1923	14190(2.16)	154(----)	7144(0.71)
1924	15002(1.61)	237(1.27)	6910(1.40)
1925	14126(1.88)	223(0.45)	6807(0.68)
1926	14457(1.76)	188(----)	6627(0.42)
1927	15239(1.88)	328(----)	5990(0.63)
1928	14713(1.96)	275(----)	5991(0.45)
1929	16150(1.60)	225(----)	5619(0.89)
1930	16583(1.83)	225(----)	5790(0.95)
1931	16256(1.64)	252(----)	5400(0.81)
1932	14946(1.90)	266(----)	6127(1.03)
1933	14426(1.39)	300(----)	5886(0.99)
1934	14054(1.23)	319(----)	5391(1.00)
1935	14942(1.17)	390(----)	4622(0.84)
1936	15126(1.14)	257(----)	4173(0.55)
1937	15470(1.19)	193(0.52)	3375(0.41)
1938	14959(0.99)	190(----)	3081(0.39)
1939	15238(0.95)	205(0.98)	2988(0.94)
1940	16477(0.86)	245(1.63)	2994(1.00)
1941	15709(0.96)	330(0.91)	2775(1.23)
1942	15654(0.76)	431(----)	2465(1.50)
1943	16130(1.12)	493(1.83)	2232(1.79)
1944	16286(1.15)	485(0.62)	1711(1.99)
1950	20840(NA)	295(NA)	757(NA)

²⁷⁷From the Annual Reports 1915-1950, Department of Health.

Appendix 8

The Record Book of Nurse Jean Scott of Cupar

This record book is reproduced here (courtesy of Frances Gaber, Cupar) to give some idea as to the kind of cases Nurse Scott was willing to admit. Where medical condition/treatment is not detailed and the stay is more than two days but less than ten as in maternity cases, one can only speculate on what procedure was being performed. Note that Nurse Hastings, her trained nurse, is referred to as a doctor while Nurse Scott herself does not mention attending any treatment of patients.

1927

January 5 female ovariectomy Drs. Stuart and Hastings \$58.00
discharged January 22 Cupar

January 7 female appendectomy Drs. Stuart and Hastings \$55.00
discharged January 23 Cupar

January 10 male extraction of 19 teeth general anesthetic
\$5.00

January 10 male appendectomy Drs. Stuart and Hastings \$73.00
discharged Feb 1

January 17 female Dr. Stuart t & a (tonsils and adenoids)
\$5.00 discharged January 17

January 1930

January 6 female appendectomy Dr. Stuart \$43.00 discharged
January 18

Feb 15 female OB Dr. Stuart \$47.00 discharged Feb 25

Nov 9, 1929 female \$73.00

Feb 24 1930 same female as above \$42.00 March 7
car accident OB Dr. Stuart

Feb 26 female \$47.00 OB Dr. Stuart

Mar 2 female discharged Nov 12 \$42.00 OB Dr. Stuart

March 3, 1930 female \$81.00 OB Dr. Stuart discharged April 15

March 4 ? general anesthetic amputation finger Dr. Stuart,
discharged Mar 5 \$5.00

March 6 male appendectomy Drs. Stuart and Hastings \$38.00
discharged March 16 paid \$25.00

March 20 female t & a \$6.00 discharged March 21 Dr. Stuart

Mar 20, 1930 male appendectomy \$44.00 discharged April 1

Mar 24 female kidney complications \$21.00 Dr. Stuart
discharged Nov 31

Mar 27 female ovariectomy right side
appendectomy Drs. Stuart and Hastings \$53.00 discharged April
11

March 29 female ovariectomy right side, Drs. Stuart and
Hastings \$59.00 discharged April 15

Mar 31 male appendectomy, Drs. Stuart and Hastings, \$28.25,
discharged April 5

April 5 same as above removed to pest house with small pox

April 1 male t & a, Dr. Stuart, \$7.00

April 6 female OB Dr. Stuart \$42.00, discharged April 16

April 17 male appendectomy, Drs. Stuart and Hastings, \$41.00,
discharged April 28

Apr 22 female appendectomy, \$38.00, Drs. Stuart and Hastings,
discharged May 2 July 1 car accident 6.40 Aug 1 Drs. Stuart
and Hastings 5.10

May 8 female OB Dr. Stuart, \$49.00, discharged May 20

May 17 female OB Dr Stuart \$42.00 discharged May 26

May 20 male appendectomy Drs. Stuart and Hastings, \$41.00
discharged May 31

May 22 female OB Dr. Stuart, \$43.00 discharged June 1

May 27 female appendectomy, Drs. Stuart and Hastings, \$57.50
discharged June 12

May 27 male appendectomy, Drs. Stuart and Hastings, \$37.00
discharged June 5

May 28 female appendectomy, Drs. Stuart and Hastings, \$50.00
discharged June 11

June 2 female \$25.00 discharged June 8

June 5 male appendectomy, Drs. Stuart and Hastings, \$38.00, discharged June 16

June 14 female abscessed arm, Dr. Stuart, discharged June 20

June 18 male appendectomy, Drs. Stuart and Hastings, discharged June 29, \$40.00

June 21 appendectomy, Drs. Stuart and Hastings, \$38.00, discharged June 30

July 4 male fractured hand, Dr. Stuart, \$14.00, discharged July 8

July 6 female ovariectomy and appendectomy, Drs. Stuart and Hastings, discharged July 21

July 7 male appendectomy, Drs. Stuart and Hastings, discharged July 17, \$37.00

July 12 female, \$23.00, discharged July 19

July 13 female, \$15.00, discharged July 19

July 13 male appendectomy, \$35.00, discharged July 22

July 21 female appendectomy, Drs. Stuart and Hastings, \$40.00, discharged Aug 1

July 16 female OB, Dr. Stuart, \$40.00, discharged July 26

July 15 female appendectomy and ovariectomy, Drs. Stuart and Hastings, \$52.00, discharged July 30

July 25 female OB, Dr. Stuart, \$50.00, discharged Aug 5

Aug 2 ? \$5.00, discharged Aug 2

Aug 5 female, \$19.00, discharged Aug 10

Aug 9 female appendectomy and ovariectomy, \$53.00, discharged Aug 23, Drs. Stuart and Hastings

Aug 15 female, \$14.00, discharged Aug 19

Aug 11 female OB, Dr. Stuart, \$42.00, discharged Aug 21

Aug 20 female, \$7.00, discharged Aug 21

Aug 20 female, \$20.00, discharged Aug 27

Aug 22 female, \$5.00, discharged Aug 22

Aug 22 female ruptured appendix, \$85.00, discharged Sept 16,
paid \$12.50

Aug 27 female, \$59.00, discharged Sept 12

Aug 30 male, t & a, \$5.00, discharged Aug 30

Aug 30 male, t & a, \$5.00, discharged Aug 30

Sept 12 female septic sore throat, \$32.00, discharged Sept 21

Sept 13 male appendectomy, \$37.50, discharged Nov 22

Sept 20 male, \$78.50, discharged Oct 13, paid \$57.50

Sept 27 female, \$56.00, discharged Oct 13

Nov 3 female, \$83.00, discharged Nov 28, paid \$65.50

Nov 5 male, \$17.00, discharged Nov 10

Nov 5 female, \$25.00, discharged Nov 13

Nov 8 female, \$25.00, Nov 12 died @9PM

Nov 14 male, Nov 23 died @ 8PM, \$37.00 Nov 29 by cash 20.00

Nov 14 female, \$42.00, discharged Nov 25

Nov 20 female, \$5.00, discharged Nov 20

Dec 1 ? \$81.75, discharged Dec 24

Dec 21 female, \$59.00, discharged January 7

Dec 22 female, \$21.00, discharged Dec 29

Dec 28 female, \$32.00, discharged January 6

Jan 9 female, \$42.00, discharged January 19

Feb 3 ? \$42.00, discharged Feb 13

January 10 female, \$71.00, discharged Feb 6

Based on the records above, which are reproduced exactly as Nurse Scott originally recorded in them in her ledger book, the following statistics are found. Please note that hospital days are calculated by counting the day of admission but not

the day of discharged except in cases where treatment took only one day. These figures are based on the information provided only - no speculations as to discharge date, sex or medical condition have been made.

Number of female patients	52
Number of male patients	20
Gender unclear from records	5
Total Number of Patients	<hr/> 77
Length of Stay in Days	
Average (Both males and females)	11.6
Average male	9.6
Average female	12.0
Attendance at treatment	
In total	
Dr. Stuart	20
Drs. Stuart and Hastings	22
for females	
Dr. Stuart	17
Drs. Stuart and Hastings	12
for males	
Dr. Stuart	2
Drs. Stuart and Hastings	9
Charges for Treatment	
Average cost for females	\$39.33
Average cost for males	\$32.64

Rural Municipality Payments to Nurse Scott's Maternity Home
in Cupar, October 31, 1936

MARKINCH
SASKATCHEWAN

Miss Jean Scott,
Cupar Nursing Home,
Cupar, Sask.

Enclosed you will find Municipal cheque
for \$527.50 being payment of the following
Hospital accounts,

Yours truly,

Secy Treas.

Leavings	
✓ Mrs Beale	20. 00
✓ Mrs Sandbrook	12. 50
✓ Ruthleen Council	20. 00
Elise Zige	20. 00
Arnie Stark	20. 00
	102. 50

Yours truly,
 W. L. Leggett
 Secy Treas. L. B. Lagan
 of Belding
 Jan 12, 1903
 Ed. Lagan
 L. B. Lagan, Jan. 15, 1903

Appendix 10

Community Poem to Mrs. Inglis of Lumsden

The following poem is from a scrapbook "compiled and given to Mrs. Inglis at a time when she was taking a trip back to Scotland", roughly 1979. It includes several photographs of people she delivered and is displayed in the Lumsden Museum, along with several items from her cottage hospital. From this exhibit, it is clear what a great role Mrs. Inglis played in this community.²⁷⁸ The poem below gives some insight into the personality of Mrs. Inglis and the nature of her maternity services in Lumsden while personalizing the business of maternity care.

We'd like to include all the funny little things
The days and the nights and the culture that brings

If only Mrs. Inglis would tell us the truth,
Who screamed and who didn't, so on and forsooth

Our first picture for the book so fine
Is Edith Pryke born in 1929...

The Ab Wills had a family numbering four
Three born at Mrs. Inglis' right near the store...

When Elessors their 25th anniversary were celebrating
Betty Balfour was kicking and tire of waiting
so right on the evening of that very night,
Dr. Lindsay and Mrs. Inglis showed her the light...

Mrs. Schadlich had Robert and Dennis under her care,
Then three had tonsils and adenoids which gave her a
scare.
She's not too well now but sends her best wishes,
You boiling the linens and still time for the dishes.

Rae and Howard were two of your flock,
of course you know they came of good stock,
but we'll never forget your kindness and care,
when out on the farm with Rae you did more than your
share...

²⁷⁸In addition to the museum exhibit of Mrs. Inglis' operation, her maternity home is also part of a heritage walking tour of Lumsden. Mrs. Rachel Biron's home, which she bought in Maple Creek in 1913 and converted to admit maternity cases, is the only other nursing home to be designated in a walking tour as having historical significance.

Dr. Lindsay and Mrs. Inglis were at Bakewell's house
 Helen Majury was sleeping as peaceful as a mouse,
 She wakened up and cried with pain,
 Sent Toots for her Mother and the Doctor again
 When they arrived once more Helen was sleeping,
 but Pat did arrive before dawn was breaking...

A suitcase for an incubator with Batting and Bulb,
 Said Marge "Make her cry, give one more rub"
 Sharon started squawking and kicking about,
 Sure enough she grew up and now we all shout,
 Sharon in her kilts will say
 have a happy holiday...

In some babies lives the war played a roll,
 When things were rationed especially coal,
 But though Mrs. Inglis was worried about heat,
 the Clatworthy baby took her attention complete.
 By morning Joyce Lois was breathing,
 the coal almost gone,
 so now Mrs. Inglis our thanks lingers on...

Duane Cookson was kicking his way in a fashion
 alarming to Doctor and Nurse Inglis a dash'n,
 so off to Regina they took this patient tough,
 Now Rogers Supply keeps him doing his stuff...

The last in the cottage hospital was a boy named Jim,
 Enid and Les McLaren were the parents of him.
 Enid and Mrs. Inglis were irked by the stockings long,
 But the doctor insisted nothing was wrong
 It was about this time that Mrs. Inglis was tired,
 so right after that case we see she almost retired...

Neil Henderson arrived in a rush,
 which called Mrs. Inglis to the house to hush,
 they delivered the baby but the doctor thought wise
 to take Mother and baby to hospital to supervise
 They said "He's contaminated and can't join the nest,
 But must stay with his mother who then got no rest..."

The patients were moved from one room to the other,
 especially to help the doctor and patient recover,
 so when Sharon Curtis was quite new born,
 Brydens were coming maybe by morn.
 So a move was made which seemed quite soon,
 but something went wrong, maybe the moon.

Appendix 11

Demographic Profile of the Patients of Mrs. Inglis, July 6, 1935 to August 18, 1941

Margaret Inglis was a Scottish-born maternity home operator for over 23 years in Lumsden, Saskatchewan. Left to make her own way after the early death of her husband and with four young children, she eventually was contracted to take all of the local doctor's maternity patients. The maternity home, according to Mrs. Inglis, saw the birth of over 325 babies. Before she died in 1994, a few days short of her 104th birthday, she had been widely applauded in her community for the services she had provided and her contribution to community cohesion.²⁷⁹ What follows is an analysis of those using "Maggie the Midwife's" maternity home in Lumsden from July 6, 1935 to August 18, 1941, a total of 33 patients and 33 deliveries. All information is taken from the Province of Saskatchewan Record of Registration of Birth. All records accounted for below name "Cottage Hospital", "Nursing Home" or "Mrs. Inglis'" as the place of birth.

Racial Origin of Mother		Birthplace of Mother	
English	8	Saskatchewan	23
Irish	8	Ontario	4
German	7	Nova Scotia	1
Scotch	8	Ireland	2
Polish	1	Germany	1
Austrian	1	Manitoba	1
		Russia	1
Average Age of Mother		26.5 years	
Lowest Maternal Age		19 years	
Highest Maternal Age		43 years	
Mode Maternal Age		21 years	
Median Maternal Age		25 years	
Average Number of Children of Mother (including current birth)		2.42	
Number of Multiple Births		1	

²⁷⁹A good portion of the biographical information on Maggie Inglis comes from D.J. Dale, "Western People: Maggie the Midwife - A Good Cup of Tea Was Her Prescription for New Mothers," The Western Producer, June 13, 1991.

Number of Stillbirths in Mothers' Medical History	3	
Percentage of First Time Mothers	30.3	
Percentage of Births Attended by a Doctor and Mrs. Inglis	87.9	
Percentage of Births Attended by Mrs. Inglis alone	12.1	
Percentage of Live Births Registered	100	
Average Length of Marriage Before Birth of Baby	4.58	years
Percentage of patients married less than nine months before delivery (for those detailing exact date of marriage)	9.1	
Fathers' Occupations		Residence other than Lumsden ²⁸⁰
farmer	20	Silton
labourer	6	Craven
general merchant	1	Tregarva
store clerk	1	Zehner
cook, CNR Railroad	1	Mossbank
carpenter	1	Last Mtn. House
grain buyer	1	
instrument maker, Royal Canadian Air Force	1	
service station attendant	1	

²⁸⁰These areas all surround Lumsden in a radius of approximately 15 kilometres, with the exception of Mossbank, which is almost 150 kilometres away. All towns were connected by rail in this era and developed roadways.

Appendix 12

Birth Announcements and News Items in The Shaunavon Standard Related to Prairie Maternity Homes

There are several points of information that can be gleaned from references to nursing homes in historic prairie newspapers. Both birth announcements and local news items that involve injury or illness give an indication of the patient's nationality, geographic place of residence (and therefore the area that a given nursing home served) and treatment needed, in addition to what sorts of medical conditions nursing homes were seen to be able to deal with. Because births, marriages and deaths were inserted in the paper free of charge, there was no disincentive to submit them. This particular range of time in The Shaunavon Standard is used because it included a large number of references that were especially useful in observing what occurred in a town with more than one maternity home and a public hospital, built in Shaunavon in 1917.

The standard birth announcement of a child born in a nursing home follows the general format of this declaration found in The Shaunavon Standard on March 17, 1932:

Born at MacKenzie's Nursing Home, to Mr. and Mrs. Theodore Meier of Gergovia, on March 14, a son.

Here we can see that Mrs. MacKenzie had a French-Canadian family in the home and the chances of the child's survival, partly due to the assistance of Mrs. MacKenzie no doubt, are good because the birth announcement was published three days after the delivery. Because births at each home are grouped together for each issue of the paper, it is possible that the matrons themselves submitted the details of their work directly to the paper. Perhaps it was a round-about way of advertising, or at least a way of letting the community see that the business was active and taking patients. While birth announcements were free, classified ads not exceeding five lines were 50 cents per admission and each additional line cost 10 cents. It definitely would have been cost effective to advertise through birth announcements, especially when births were the bulk of the business. An announcement from September 22, 1932 gives greater insight to the nature of maternity work:

Born at Ross' Nursing Home September 14 to Mr. and Mrs. Gustaf Reberger of Shaunavon, a daughter; September 15 to Mr. and Mrs. August Moyer of Shaunavon, a daughter; September 21 to Mr. and Mrs. Harty Sharp, a daughter.

Assuming that each of these women stayed in the maternity home for the required standard of ten days recuperation, Mrs. Ross

would have had three patients and three babies to care for at one time. Note also that if a doctor was assisting at these births, he/she is not mentioned whereas the name of the maternity home is the first item of information. That these women were experts in the maternity field is obvious in another announcement in the May 12, 1932 issue:

Born at the Ross Nursing Home on May 5, to Mr. and Mrs. Adolf Dynna, Chambery, twin girls; and to Mr. and Mrs. J.W. Lett, Cadillac, on May 5, a son. Mr. and Mrs. Lett were the happy parents seventeen years ago of triplets, all living.

It is clear then that nursing home operators were able to handle multiple births successfully and those with a history of multiple births. Note also that Mrs. Ross delivered a total of three babies in one day.

Much non-maternity related work also took place in both Mrs. Ross' and Mrs. MacKenzie's homes, and in a number of cases when one would assume that they would head to the hospital, patients went to a nursing home for medical attention:

Lawrence Larson, 4-year-old son of Mr. and Mrs. Lawrence Larson, of Dollard, was brought to the MacKenzie Nursing Home Sunday (April 17) suffering from a scalp wound where he was kicked by a horse while feeding the animal. He is getting along nicely²⁸¹.

Frank, age 9 and Alfred, age 11, sons of Walter Olsen, residing near Ravenscrag, were driving home in a buggy on Saturday afternoon, when the horse suddenly took fright and ran away, throwing the two lads out onto the road. Frank had his right arm broken and Alfred suffered a broken left leg. Both received treatment and are progressing favourably at MacKenzie's Nursing Home²⁸².

These types of news items are interesting in that they give some indication of the types of emergency situations. In addition, because most of the non-maternity related patients are children, perhaps one can conclude that parents took their children to a nursing home to ease the child's fears about

²⁸¹The Shaunavon Standard, April 21, 1932.

²⁸²The Shaunavon Standard, June 2, 1932. Broken bones seemed to commonly be treated at the local maternity home. The July 7, 1932 issue of the Standard carried a story of a six year old who fell through the floor of a loft to the lower part of the barn, broke his arm and was convalescing at Mrs. MacKenzie's. The same issue reported a man who fractured his collar bone was also 'resting comfortably' at the same nursing home.

their own condition. In some cases, children would be returned for treatment to the homes they were born in and by a woman who they knew as a neighbour or family friend. The hospital would have been very frightening to a small child.

Long term patients were also nursed in Shaunavon's nursing home:

Mrs. M.M. Mattson has returned home from Shaunavon, where she was a patient at MacKenzie's Nursing Home for several weeks. She is slightly improved in health after two weeks' illness²⁸³.

Mrs. S.C. Hustoff returned to her home north of Admiral Sunday afternoon. Mrs. Hustoff has been ill for some time at the Ross Nursing Home in Shaunavon²⁸⁴.

While it is difficult to speculate what medical condition these women had that demanded long term care at a maternity home, it is clear that long term patients, while more work, would also have meant a steady income for the matron. As is common in medical emergencies, maternity cases and long term care, death was also reported to have occurred at these nursing homes. Two news items show how this was done, the first part of an obituary and the second as part of a birth announcement:

The death occurred Friday evening at the Ross Nursing Home of Mrs. Jack Milne from blood poisoning, at age 58. The deceased had no children²⁸⁵.

Born at the Ross Nursing Home on July 2 to Mr. and Mrs. Lawrence Jackson, a son and on July 5, to Mr. and Mrs. H.N. Kehney, Ravenscrag, a son (stillborn)²⁸⁶.

²⁸³The Shaunavon Standard, August 11, 1932.

²⁸⁴The Shaunavon Standard, December 1, 1932.

²⁸⁵The Shaunavon Standard, June 2, 1932.

²⁸⁶The Shaunavon Standard, July 7, 1932.

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