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HOSPITAL-BASED NURSING AND THE LABOUR PROCESS,
ONTARIO, 1850-1922

BY

LES I. TEICHROEW

A THESIS SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS.

DEPARTMENT OF
SOCIOLOGY AND ANTHROPOLOGY

CARLETON UNIVERSITY
OTTAWA, ONTARIO
AUGUST, 1987

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ONTARIO, 1850-1922"

submitted by Les Ian Teichroew, B.A. Hons.
in partial fulfillment of the requirements for
the degree of Master of Arts

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ABSTRACT

This thesis examines the historical development of hospital-based nursing and its labour process in Ontario between 1850 and 1922. By building upon feminist critiques of Marxist theory, the thesis seeks to apply class and gender as empirically significant concepts. The analysis proceeds at two levels of abstraction. First, it locates the emergence of nursing vis-a-vis the growth of hospital-based care, both of which were influenced by broader changes in society, the economy and family. Secondly, it links changes in the content and control over nurses' work to those broader social changes, and more specifically to the struggles between physicians, hospital administrators, and nursing superintendents at the level of the workplace, namely the hospital.

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It would require many pages to thank all those who had a role in the writing of this thesis. At the risk of omitting those who, in one way or another, contributed to this effort, I will instead attempt to briefly recognize some of the more notable, although perhaps no more important contributions.

First, I must thank my family for their interest in, and uncritical acceptance of, my work. In an environment where critical commentary is endemic, non-conditional acceptance can be very hard to come by in the halls of academia. For their support I am very grateful.

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PART I

CHAPTER 1: INTRODUCTION

It is well known that most nurses are women. But women have historically also had an important role as independent lay-healers and midwives in western society, an observation that Ehrenreich and English (1973) state has been obscured by their current status as subordinate practitioners in a medically dominated health care system. They argue that the domination of female health care practitioners needs to be explained lest it be considered "natural". Following Ehrenreich and English, this thesis will focus on the emergence and subordination of a particular body of female health care workers, registered nurses, in Ontario hospitals between 1850 and 1922.

More specifically this analysis will address some neglected aspects of historical analyses of nursing in Canada. Conventional nursing histories are presented as historical accounts rather than historical interpretations, typically relating chronologies of events or focusing upon "great" individuals in nursing (Davies, 1980). Canadian examples of the former include Gibbon and Mathewson (1947) and the Canadian Nurses' Association (1968) in sketching nursing developments across Canada, Paffard (1913) in chronicling the Graduate Nurses' Association of Ontario's history, and Macbeth (1959) in writing of the Lady Stanley Institute for training nurses in Ottawa. The latter

approach, the "great" person focus, is reflected in Street's (1973) biography of Ethel Johns, and The History of Nursing Society's (n.d.) descriptions of some early figures in Canadian nursing.

Although important documents of nursing's past, conventional nursing histories have fundamental difficulties that make that history more difficult for us to understand.¹ Three major concerns are apparent and will be addressed in this thesis: their methodological approaches, their theoretical orientations, and their substantive focus. Methodologically, nursing chronologies relate a process of unilinear progress with each historical event necessarily occurring outside of the intervention of the nurses themselves. As a consequence, the uneven and slow nature of change is neglected and nurses are effectively denied a collective role in influencing their own history. "Great Person" accounts, on the other hand, explain nursing history as an outcome of the efforts of one (or more) individuals, and thereby do not relate them to the broader social, economic and political context. Theoretically, these histories do not systematically analyze the empirical significance of class and gender relations in terms of nursing development. There is no thorough assessment of the class or gender dynamics in the relationships between lower-class nurses and their higher social-class superiors, which include nursing

superintendents, physicians and hospital administrators. Authors such as Gibbon and Mathewson (1947) and MacDermot (1940) implicitly, if not explicitly, assume that nursing is lower-class women's work, without even questioning this assumption. Lastly, regarding their substantive focus, these general and abstract discussions of either developmental patterns or particular individuals' experiences, do not deal with changes in the nursing labour process. As a result the relationships between nurses and nursing superintendents, physicians, and hospital administrators, as they affect the content, organization and control of nurses' work, are not analyzed.

However, two works relating to Ontario are exceptional.² Coburn (1974), in a brief but important statement on Ontario nursing history between 1850 and 1930, recognizes the influences of the institutionalization³ of health care, feminine ideology and the "lure of professionalism" in nursing development. While acknowledging their significance, she does not analyze these factors in relation to broader social and economic changes. Neither does Coburn's analysis deal with the struggle between nurses, physicians and hospital administrators for control of the form and content of nursing practice, that is, of the labour process. Falcon (1984), on the other hand, explicitly focuses on the nursing labour process. While theorizing the formal and

real subordination of nursing in nineteenth century Ontario, there is little attempt to systematically relate women's roles in the family and economy to these changes. Moreover, by analyzing the labour process in terms of its formal and real subordination, Falcon retains the marxian emphasis on class, and is therefore (as I will later argue more generally) unable to provide a theoretically adequate account of the simultaneous influences of gender and class.

This brief review indicates a need to reconsider nursing history by examining the labour process within a broader context of socio-economic change, through the concepts of class and gender. This thesis proposes to provide such an analysis of the hospital-based nursing labour process in Ontario between 1850 and 1922.

I will argue that changes in the nursing labour process must be seen at two levels of analysis. At a more abstract level of analysis the development of nursing as women's work will be seen in the context of commercial capitalist development. It will thus be possible to isolate the structural and ideological conditions as they are shaped by class and gender relations. These conditions affected the kinds of paid labour which have been available to, or sought by, women, and facilitated the emergence and focus of institutionally-based health care. The ideological significance of morality for social reform will also be explored, particularly in relation to the emphasis of

hospital care and efforts by nursing superintendents to reform nursing into a respectable occupation for middle-class women. On a more concrete plane this thesis will deal with the hospital-based nursing labour process. While acknowledging broader social and economic influences upon the workplace, the concern will be to explicate the ways in which the struggles for control waged by nursing superintendents, the medical profession and hospital administrators influenced the organization, content and control of nurses' work. I will argue that gender and class, the predominant middle-class morality in particular, affected the strategies taken and control obtained in the conflict between these three occupational groups.

While a marxian orientation is useful in assessing the influence of class relations, I will maintain that its gender-blindness necessitates a selective application of a marxist-feminist approach in order to capture the role of gender in the development of nursing and its labour process.

The scope of this thesis, including the time frame, region, and focus on hospital-based nursing in public general hospitals, require comment. The periodization and geographic specificity are significant because Upper Canada, later Ontario, was throughout the mid-nineteenth to early twentieth century an important and early site of fundamental changes in the socio-economic conditions of

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Canadian life (Spelt, 1972; Cross and Kealey, 1982).⁴ The Ontario Nurses Registration Act of 1922 was intended by nursing leaders to herald an era of reform in nursing, and thus represents an appropriate point to conclude the analysis. Further, because of the allocation of responsibilities for health care and education to the provinces through the British North America Act of 1867 (Wallace 1980), the analysis of the other provinces and territories would require a consideration of factors unique to them.⁵

The focus on hospital-based nursing is indicated for two reasons. Social welfare institutions, and institutionalized health care in particular, grew in importance in Ontario's emerging commercial capitalist society. This thesis presents an opportunity to examine the role of nursing as affected by these changes. However, the hospital is important not only because of nursing's place within it, but also as a locus of struggle by the medical profession and "professional" hospital administrators to delineate spheres of influence and control.

Further, the analysis will discuss the nursing labour process in public general hospitals, leaving aside an assessment of specialized institutions, such as lying-in, women's, children's and mental hospitals, and privately run hospitals. Previous analyses suggest that the nursing labour process in these institutions differed from that in

public general hospitals (Melosh, 1982; Reverby, 1982). It is also clear that public general hospitals were an initial product of efforts to institutionalize health care (it was not until later in the nineteenth century that specialized and privately-run institutions emerged) and constituted the major focus of hospital-based care in Ontario. Thus, by concentrating upon public general hospitals a broader picture of change in the nursing labour process can be obtained.

Other facets of nursing, including the labour process within private duty nursing, public health nursing, and the Victorian Order of Nurses, will not be analyzed. The unique dynamics presented by their work within the community and frequently outside of direct medical and nursing supervision necessitates a separate discussion. The case of private duty nurses is somewhat more difficult to disregard since they too occasionally worked within the hospital, although it is on the basis of their employment by the patient and not the hospital that their exclusion is justified. Further, although the training experiences of nursing students often included working in homes, the labour process relating to this work will not be analyzed in any detail, since the differing relationship of the student to the client and their immediate superiors in the home vis-a-vis the hospital demands a separate examination.

Having reviewed the parameters of this analysis, an

appropriate conceptual framework needs to be elaborated. Before doing so, a brief description of the data limitations in this analysis is in order.

METHODOLOGICAL CONSIDERATIONS

A review of sources is important because of the potential constraints they present to this analysis.

Perhaps most notable is the general lack of data. There are few primary and even secondary, quantitative or qualitative sources in regard to the historical development of nursing in Ontario. The sources used nonetheless deserve mention. Primary materials have been utilized as extensively as possible. Of these, The Canadian Nurse, minutes of nurses' association meetings, medical journals, and other hospital documents, such as the yearly reports from the County of Carleton General Protestant Hospital in Ottawa, are the most important. Important secondary sources include Gibbon and Mathewson (1947) and the Canadian Nurses' Association (1968) on Canadian nursing history, MacBeth's (1959) review of the Lady Stanley Institute in Ottawa (other histories of training schools were utilized, although they were not as detailed), MacNab's (1970) review of nursing legislation in Ontario, Street's (1973) biography of Ethel Johns - a significant figure in nursing during the early twentieth century - and the detailed histories of particular Ontario hospitals by Angus (1973),

Clarke (1913), and Cosbie (1975).

The content and relative absence of data necessarily influence the interpretations that can be generated. Hence, the thesis runs the risk of missing aspects of nurses' experiences within the hospital, including their work, education and relationships to nursing superintendents, physicians and hospital administrators. Despite the utilization of nursing-related reports in medical and hospital-oriented sources, this possibility cannot be ignored since much of the secondary and primary material is only indirectly relevant to nursing and its labour process. Further, since most of these sources were written by middle-class individuals, they reflect the views of their authors. One consequence, among others, is that the voices of lower-class women actually "doing" nursing are remarkably absent, thus creating the impression that they were not active participants in their own history. In other words, this analysis is a "reconstruction" of the changing work and education of nurses within the hospital.

CHAPTER 2
THEORETICAL FRAMEWORKS:
GENDER, CLASS AND THE LABOUR PROCESS

In this chapter I will develop a framework for the analysis that takes class and gender to be empirically significant concepts. It will be argued that orthodox marxian theory has been unable to accommodate gender conceptually because of its class emphasis. Instead I use marxist-feminist theory selectively to inform the following discussion.

MARXIST-FEMINIST CRITIQUES OF MARXIST THEORY

Marx's (1954) conception of the labour process is based upon wage dependency, and hence deals largely with the relationship of genderless workers to capital.¹ Class struggle, then, is central to its analysis. Feminists maintain that the analytic primacy of work and class struggle have important consequences for marxist's explanations of women's work.

One such difficulty is that women's role in reproduction (Jaggar, 1983),² defined as the daily and generational reproduction of labour power (Seccombe, 1980), is neglected. Bradby (1982) and Omvedt (1986) attribute this neglect to the marxist conception of labour as that concerned with production for exchange, thereby excluding and devaluing women's non-productive (that is non-productive of surplus value) labour in the home. By

concentrating on paid labour and class struggle Marxist theorists do not discuss explicitly women's role in reproduction, but assume instead that the household's reproductive needs will be largely met through her labour (Armstrong and Armstrong, 1985).

The separation of production from reproduction also divorces analytically the public and private spheres (Morgan and Taylorson, 1983; Saunders, 1983). Domestic and wage labour then occupy two distinct spheres, with women being oppressed through gender-based mechanisms in the home, and exploited through class-based mechanisms in the workplace. Consequently, these explanations deny that women are exploited by gender in the workplace or by class within the household. Instead, Ursel (1984) argues that just as class relations are not confined to the workplace (see Rubin, 1976), so too relations of male domination are not confined to the family. Work and family, public and private, are inextricably intertwined (Gannage, 1986). In other words, one cannot analytically separate women's role in the family from that in wage labour (Barrett, 1980; Pollert, 1983).

Marxist analyses also tend not to adequately explicate the link between material and ideological processes in conditioning women's oppression (Barrett, 1980; Benton, 1984). Again, at issue here are the conceptual primacy of class domination and hence also the functionality of

ideological modes of reproduction to capitalism. Feminists maintain that since marxist conceptions of ideology are concerned with the reproduction of class relations, they cannot account for the continuance of gender domination. Further, some argue that feminists' appropriation of marxist accounts of ideology frequently tend to explain the reproduction of gender ideology solely in terms of the needs of capital (Barrett, 1980; Pollert, 1983). Although Barrett accepts that ideology can be functional for the reproduction of capital, she criticizes these explanations for being overly reductionist, conspiratorial, and argues that they are unable to recognize the significance of patriarchy in shaping women's consciousness. In other words, Barrett advocates a conceptualization of ideology that can explain the reproduction of both capitalist and patriarchal social relations.

While it is not within the domain of this discussion to engage in an extended critique and reformulation of the concept of ideology, a brief account of its use within this analysis is necessary. Following Larrain (1979) and Thompson (1983), the concept of ideology will be employed in a restrictive sense, referring to the false consciousness which is generated in an attempt to resolve the contradictions of material life, but which instead reproduces relations of domination.³ However, for our purposes domination will include class as well as gender-

based forms. Following this line of reasoning Barrett (1980) and Pollert (1983) argue that women's assumed or ideologically prescribed, and actual responsibilities in domestic labour affect their propensity to seek wage labour and their experiences of said work, while they simultaneously perpetuate their oppression in the home in class-specific forms. In other words, ideology and material conditions may mutually interact to reinforce oppressive class and gender relations.

It should be apparent from these brief comments that women's work cannot be explained satisfactorily in terms of the logic of the capitalist system (Phillips and Taylor, 1980), lest it be reduced to a product of class struggle (Apthias and Yuval-Davis, 1983; Young, 1981), or ignored altogether (CSE Sex and Class Group, 1982).⁴ In order to adequately analyze the labour process of nursing gender must also be included as an explanatory concept.

Feminists, although widely criticized for doing so, commonly operationalize gender through the concept of patriarchy (Beechey, 1977; Omvedt, 1986). Barrett (1980) maintains that the concept of patriarchy has deleterious effects on feminist's theories, since it is frequently used in a transhistorical and universal sense and thus precludes the possibility of culturally and historically specific analyses of male domination. As she documents, even analyses of pre-capitalist societies fail to recognize the

historical specificity of male domination by positing the transhistorical existence of patriarchy.

Much of Barrett's objection to the indiscriminate use of the concept patriarchy concerns the consequences of particular applications. Apart from ahistoricity, male domination over women is confused with the domination of the father over women (McDonough and Harrison, 1978), or generates dualistic models of social reality (Kuhn, 1978). Continued use of the concept (Hartmann, 1979; Seccombe, 1980) suggests some conceptual utility, although one must, as Barrett cautions, indicate the historical and cultural variability of male domination.

Having identified some difficulties in accommodating both class and gender conceptually, one can better specify the parameters within which a discussion of changes in the labour process of hospital-based nursing should take place.

ANALYZING THE LABOUR PROCESS IN NURSING

Mohun (1983:267) points out that

the labour process is a condition of human existence...But to see how different human participants relate to one another in the labour process requires consideration of the social relations within which that process occurs.

Following Mohun, those social relations, in this case between nurses, nursing superintendents, physicians and hospital administrators, will be taken as the basis for change in the nursing labour process. I will now indicate

how the framework for this analysis is to be conceived.

As indicated earlier, class and gender must be taken as empirically significant concepts. Capitalist class-relations are one element in explaining the transition from a reliance on the self, family and and community for health care to dependence on institutional forms of care, and the creation of a specific occupation to care for those individuals, namely nursing. Commercial-capitalist development affected families' abilities to reproduce thereby not only creating a demand for institutionally-based health care, but also among the urban and rural lower-class provided the individuals with work within those institutions. While class can account for the entry of the lower-class into subordinated work such as nursing,⁵ it does not explain why it was that women, instead of men, did so. Women were hired as nurses for a number of reasons, one of the most significant being that the work was seen as an extension of women's domestic responsibilities: women's work.

In like manner, class can in part account for efforts by hospital administrators, physicians and nursing superintendents to gain control over the nursing labour process. For example, hospital administrators saw nurses as a cheap and malleable source of labour that could be exploited, while physicians, once they had begun to actively practice within the hospital, sought to delimit

the boundaries of nursing practice lest nurses impinge on their efforts to monopolize medical practice. It is significant that nurses in Ontario were largely single and came from the rural and urban lower-class, and nursing superintendents, hospital administrators and physicians were commonly from higher class positions, since expectations of appropriate inter-class behaviour informed how nurses and their superiors interacted. Additionally, nursing was considered unskilled work and received low pay. Hence, middle-class nursing superintendents believed nurses should be subordinate to their superiors. Again, however, class does not completely explain the strategies that hospital administrators and physicians utilized or why they were successful; gender was equally important. Not only did the predominating ideology modeled after the patriarchal family portray nursing as women's work, but it predetermined the hierarchical relationship of women to men, and hence also of nurses to hospital administrators and physicians. In other words, class and patriarchal social relations affected the forms which the labour process took, and also the worker's experiences of those relations in the home and at work (Cockburn, 1983; Gannage, 1986).

As this discussion has so far suggested, one cannot satisfactorily explain the labour process entirely in terms of developments within the workplace. The form which the

labour process take are an outcome of a complex interplay of factors, including market conditions, labour supply, technological developments, prevailing ideologies, and state intervention, among others (Burawoy, 1985; Heron and Storey, 1986). Moreover, the impact of these factors on the labour process are uneven, varying historically, regionally, and between and within industries (Burawoy, 1985; Wood, 1982). The nursing labour process is also related to, in fact, cannot be seen outside of, the broader context of social, economic and family change. In this case, however, it was not so much the market conditions, but the growing dependency upon institutional forms of health care, the professionalization of medicine and thus the attempt of physicians to monopolize medical practices, the efforts of a growing group of "professional" administrators to create their own niche within the hospital, the expanding influence of middle-class nursing superintendents in reforming nursing, and last but not least the availability of a ready supply of cheap labour which contributed in shaping the hospital-based nursing labour process. However, the specific forms it took were not only historically variable, but also differed between urban and rural settings. In other words, the development of and changes in the nursing labour process were not unilinear and even.

Management (capital) also does not unilaterally impose

the organization of the labour process upon workers. Workers actively and passively resist and adapt to capitalists' initiatives as well as defend control over their work from the encroachment of others (Burawoy, 1979; Clawson, 1980; Noble, 1979). Put succinctly, the subordination of workers to management is a prolonged and uneven process. Its realization cannot be taken for granted or automatically assumed. In nursing, efforts by hospital administrators and physicians to exercise control over the nursing labour process were not passively accepted by nurses and nursing leaders. Nor, for that matter, did graduate nurses acquiesce to nursing leader's professional objectives. The specific forms the hospital-based nursing labour process took were conditioned not only by administrative prerogatives, and physician's attempts to dominate the health care delivery system, but also by nursing leader's efforts to reform nursing. Nursing leaders' efforts are particularly important since they sought to create out of nursing a respectable occupation for higher social-class women. This objective subsequently affected the strategies they implemented. While broader social conditions and conceptions of gender and class appropriate behavior limited the extent to which nurses and nursing leaders could successfully oppose attempts to control the nursing labour process, they cannot be described as passively acquiescing to the demands of their

middle-class male superiors. Nor, for that matter, did change occur in a unilinear and progressive manner, as efforts to induce change were slow and halting.

Briefly then, this analysis will need to apply both class and gender at two levels of abstraction to analyze the labour process of hospital-based nursing; the broader social context and the workplace. It will also need to remain sensitive to historical and regional variability in change, as well as the existence of resistance to efforts by different occupational groups to increase their control over the nursing labour process.

PART II

SOCIAL CHANGE
AND THE EMERGENCE OF INSTITUTIONALIZED HEALTH CARE

CHAPTER 3

WOMEN'S WORK, THE FAMILY AND SOCIO-ECONOMIC CHANGE

The history of nursing in Canada cannot be properly considered except in relation to the history of the country, particularly the social conditions... (Gibbon and Mathewson, 1947:143).

Following the advice of Gibbon and Mathewson, the development of nursing will be related to the broader context of social and economic change in Ontario between 1850 and 1922.

The development of nursing and women's entry into it must be seen as a product of the interaction between capitalist and patriarchal social relations. As previously noted, between 1850 and 1922 Ontario was the site of some important economic and social changes, which other provinces underwent in a more or less similar form in later years.

It will be argued that the changing economic and ideological conditions, and shifting relations within the family, had important effects on the emergence of nursing as work. Important here are a growing support for and dependency upon institutional forms of care for dependents, the increasing reliance upon wage labour, the emergence of employment opportunities for women in the tertiary sector, and an ideology that limited women's employment to what was considered "women's" work.

SOCIO-ECONOMIC CHANGE AND THE LABOUR PROCESSES¹

The mid-nineteenth century marks the rise of industrial capitalism in Upper Canada, later called Ontario.² Prior to 1850, agriculture and forestry were the main sources of wealth and employment for the majority of the population. The restrictive trade policy the British Government maintained with Upper Canada prevented widespread industrialization by emphasizing the export of raw products rather than manufactured goods (Aitken, 1967; Pentland, 1959). Most settlers during this period were independent commodity producers, predominantly in farming and logging. Thus, manufacturing existed largely as "handicraft" production through the 1850's, and social services in Ontario, such as health care, were uncommon and remained the responsibility of the individual, family and community.

Wage labour existed during this period, although mostly as seasonal or short-term work, a temporary arrangement since independent commodity production remained the norm and ideal. The small scale of work facilitated paternalistic relations between labourer and employer (Pentland, 1959). The general paucity of hospitals, and the tendency of those few institutions to rely upon its sick-poor clientele to work within them (Angus, 1973), meant that few women were employed in hospitals. The work was predominantly domestic labour, with control exercised

through personal relations of domination and expectations of class and gender appropriate behavior.

TABLE 1:
PERCENTAGE OF URBAN POPULATION^a,
CANADA AND ONTARIO, 1851-1931

YEAR	PERCENT URBAN POPULATION	
	CANADA ^b	ONTARIO ^c
1851	13.1	14.0
1861	15.8	18.5
1871	18.3	22.0
1881	23.8	29.9
1891	29.8	38.7
1901	34.9	42.9
1911	41.8	52.6
1921	47.4	58.2
1931	52.5	61.1

^a Urban is defined as the population living in incorporated villages, towns and cities regardless of size.

^b Source: Statistics Canada, Typology of the Canadian Population: A Proposal for a Change in the Definition of Urban and Rural Population. Ottawa, 1978.

^c Source: Spelt, Jacob The Urban Development in South Central Ontario. Assen, 1955.

Through the mid to late nineteenth century a number of associated social and economic changes are apparent in aiding capitalist development. Transportation improved, the railways in particular, provincial and foreign markets expanded, and foreign investment increased. The declining accessibility to land and European immigration supported the creation of a wage dependent, urban labour force for industrial growth (See Table 1). Between 1851 and 1881 the

per cent of the Ontario population residing in urban areas more than doubled. However, industrial establishments remained small, and employed a small, but still significant proportion of the population. Only 20 percent of the labour force in Ontario was employed in manufacturing in 1881 (Spelt, 1972), as agriculture remained the largest employer.

Confederation, in 1867, and a national economic policy demonstrated the federal government's attempt to secure Canada's economic and political future. This reality had recently been threatened by Britain's "casting-off" of Canada as a dependent colony, largely through the repeal of the Corn Laws, and the abrogation of Canada's reciprocity treaty with the United States following the protectionist north's victory in the Civil War (Aitken, 1967). Moreover, and important from an ideological standpoint, the rapidity of industrialization linked progress, science and capitalism in the public's view (Cross and Kealey, 1982). As Habermas (1970) has argued more generally, the public desire for progress, which occurs in the face of capitalist development, legitimates the pursuit of science, and hence capitalist expansion, and thereby also links the two. As I will show, this scientific-technical rationality was to have important consequences for the relative positions of the medical profession and nursing within the health care system.³

Hofstadter (1955) argues that this period of rapid social change supported the popularization of an individualistic social Darwinism. Spencer's belief that only the fittest survived encouraged an individual's pursuit of economic prosperity, and also legitimated corporate growth. Further, he equated human progress with moral progress, and maintained that the family had a vital role to play in supporting progress by instructing its children with "proper" moral values. Reformist intervention, such as state support of the sick-poor and the activities of labour organizations in improving the worker's plight, was rejected, in fact condemned, in favour of evolutionary (laissez-faire) change. Thus, while goods and services (such as health care) were commodified, the family became increasingly unable to care for its dependents, and the epidemics increased the demands for hospital-based care, this growth was achieved mainly through unsystematic, charitable means.

As wage labour expanded in Ontario during this period, so too came general changes in labour processes. The growth of industrial production and a transition toward the extraction of relative surplus value heightened the demand for less skilled and hence lower paid labourers. The primitive and uneven nature of mechanization meant that many skills could not be broken down, however. Labour-employer relations continued to be based upon personal

domination, although more impersonal bureaucratic (rationalized) forms of management began to emerge. Subcontracting (Heron and Storey, 1986) and piecework (Steedman, 1986) also became common tools for worker control.

The growth in institutional forms of care increased both women's employment in hospitals and the division of labour within them. In contrast to broader trends in labour processes, though, little deskilling was evident, a probable consequence of the lack of significant change in the nature of nursing work (in spite of the emergence of training schools for nurses). Further, control over the nursing staff continued to be based upon expectations of middle-class, gender appropriate behavior.

By the turn of the century manufacturing had been established as a major feature of an increasingly urban Ontario economy. The concentration and centralization of capital throughout the early twentieth century (Traves, 1983) diversified urban economies, as trade, finance and commerce employed larger numbers of workers. The growth of secondary and tertiary industries had overtaken that of primary industries. In fact, tertiary sector expansion exceeded that of the secondary sector (McDougall 1960).

Industry and wage labour also transformed. Technology became more sophisticated, and management became more centralized, authoritarian and systematic (Traves, 1983).

Wage work faced an expanding division of labour, while the demands for unskilled and semi-skilled labour increased, which displaced skilled workers, and work intensified. These changes indicate that employers were attempting to take more control over the labour process away from workers.

Yet, despite economic expansion, there was also unemployment. Because of the visibility of the sick-poor in urban centers, intervention by the state in order to protect property rights and maintain public order was increasingly accepted by the middle-class (Wallace, 1980). Hofstadter (1955) terms these beliefs a collectivist social Darwinism. Alongside a growing dependent population and the concurrent elimination of the family's means to caring for them, this ideological shift legitimated an expansion of institutional forms of care.

The demand for, and growth in, hospital-based care necessitated an expansion of the hospital's labour force. This was achieved by developing training schools for nurses, which functioned to supply hospitals with a stable, long-term group of workers. (The first training school in Ontario was begun in St. Catharines in 1874.) In contrast to industry, nursing work remained relatively unaffected by technology, and the impact of rational administrative practices remained diffuse and uneven within and between hospitals. Class and gender appropriate behavior also

remained important mechanisms of worker control. While the division of labour expanded somewhat, it did not effect a widespread deskilling. Instead, the work of nursing became increasingly skilled, and more specialized.

WOMEN AND THE FAMILY⁴

In the predominantly agricultural economy of the 1850's in Ontario, the family constituted the fundamental unit of production, and social and cultural organization. The contribution of each family member was needed for it to survive as a unit; although families were not necessarily self-sufficient. While most family members worked within the household, some lower-class urban families, and to a lesser extent rural families, also depended upon their children's wage labour (Bullen, 1986; Garfield, 1982). The wife's work was particularly important, especially among farm families and the urban lower-class, as she organized the household and participated in household-based production. Wives did not commonly work outside the home; instead they contributed economically by selling goods and services produced within the household, including their expertise as lay-healers and midwives.

Despite women's importance to the family, dependency upon males was expected. Women were merely the male's complement (Sedgewick, 1976). The family, and household, was patriarchal, and the eldest male was most commonly

being the household head. Further, women found it difficult to live independently since they lacked legal rights (Bassett, 1975; Cook and Mitchinson, 1976) - women were not eligible to vote, had no property rights, no rights to children, and were barred from Canadian universities and some professions - and were paid low wages when employed. Marriage, then, was a necessity, rendering paid work an interlude between childhood and marriage. Additionally, given the high fertility rates,⁵ most women's "careers" consisted of childbearing and rearing.

Women's positions in the upper and middle-class families stood in stark contrast to the labourious existence of their lower-class and rural counterparts. Reflecting their husband's wealth and social status, these women led more leisurely lives as domestic servants increasingly performed domestic tasks (Light and Prentice, 1980).⁶ Vicinus (1985) points out, however, that their exclusion from domestic functions had unintended consequences. Some began to seek fulfillment through work outside the home. Thus, their behavior stood in sharp contradiction to the dominant ideology which still held that women's success was to be achieved through marriage and measured by her husband's social status.

A rationale for women's activity outside the family was provided for married and single middle-class women through the coincidence of the image of a deteriorating

urban lower-class which accompanied capitalist development, and a maternal feminist ideology. The maternal feminist ideology accepted that women's sphere was different from that of men's, but held that women's "natural" caring capacities and abilities in domestic labour should be applied outside the home in an effort to effect social reform. Many married women involved themselves in charitable organizations directed at the social reform and the moral betterment of the lower-class (Morrison, 1976a; Morrison, 1976b; Sutherland, 1976). On the other hand, since spinsters did not "fit" the nuclear family model, a few single middle-class women tried to create an alternative to dependency in marriage by creating employment that would be seen as morally respectable for middle-class women. However, their work too often revolved around social reform (Vicinus, 1985).

One product of these efforts, the public educational system, came into evidence during mid-century in Ontario (Davey, 1975; Prentice, 1975). Its emergence, largely at the primary level, allegedly provided broader educational opportunities for all social classes, although in practice children of rural and urban lower-class families did not attend as frequently or as regularly as did their middle and upper-class counterparts owing to their continued participation in production. Further, boys attended school most frequently (Davey, 1975); not only was education less

acceptable for girls, but their potential contributions to the family precluded the possibility of attending schools.

The economic and social changes of the late nineteenth century initiated a growing dependency upon wage labour and consumer markets, although predominantly in urban centers. Among the rural and urban lower-class, the family continued to constitute an important economic unit. The former still relied upon their children's wage labour and to a lesser extent that of the wife, while the latter depended upon their children's seasonal labour. Domestic service and increasingly industry and nursing employed young, single, working-class women in urban centers. Even work for middle-class women became more acceptable than it had been during mid-century, although it was limited to work that suited their class position, namely occupations such as teaching and nursing administration (Nett, 1981; Katz, 1975).

Toward the end of the nineteenth century children of all social classes began to leave home at a later age, and to attend school more frequently, as the employment of younger children exhibited a general decline (Katz, 1975). School attendance increased among all social classes and for both sexes (Prentice, 1975), although it was limited to younger age groups (Katz and Davey, 1978), lagged in rural areas (Gaffield, 1982), and was lower for females (Gagan, 1981). Women's secondary education was restricted primarily

to private institutions, since only upper-class families could afford to send their daughters (L'Esperance, 1983). Female students were first accepted in Ontario universities at Queen's in 1878, (Cook and Mitchinson, 1976; Marks and Gaffield, 1985), and in 1883 when two non-degree granting, female-only medical schools began operations (Harris, 1976).

The consolidation of the corporate capitalist economy following the turn of the century brought further changes in the family. Overall the capitalist economy expanded and diversified, particularly in the urban centers, marking a growing dependency on the wage and consumer markets as home-based production was further displaced. The commodification of goods and services contributed to an increasing reliance upon hospital-based care as the forms and extent of health problems changed (industrial accidents). Meanwhile, family size declined as fertility rates decreased (Beaujot and McQuillan, 1986),⁷ indicating that women spent a shorter portion of their lives bearing and rearing children. However, as earlier tendencies in education and the family became stronger, women's ideological attachment to domestic labour was reinforced. Women's roles were redefined in terms of consumption and childcare as social welfare institutions and the commodification of some aspects of domestic labour narrowed their role in the home (Gaffield, 1984; Strong-Boag, 1986).

Any deviation by women from their expected responsibilities in motherhood signalled a rejection of prevailing morality (Hofstadter, 1955), and hence created resistance to women's employment in wage labour since it was considered an attack on the family (Cook and Mitchinson, 1976). This opposition came from middle-class women (Morrison, 1976a; Morrison, 1976b), trade unions and male workers (Trofimenkoff, 1981), and was supported by legislation designed to limit women and children's employment and the conditions of their employment (Ursel, 1986). This ideology, however, ignored the fact that rural and urban lower-class women frequently worked out of economic necessity (Cook and Mitchinson, 1976; Johnson, 1974), or that some middle-class women sought employment, albeit in work that more closely suited their social status, such as teaching, clerical work, and nursing administration.

Women's university attendance increased, but by 1902 only 13 percent of all university students in Ontario were female (Marks and Gaffield, 1985). Further, their enrolment was limited to courses such as education, household science, social work, library science, occupational therapy and physical therapy (Harris, 1976) - no university-based nursing program existed in Ontario prior to 1922. Higher education was still not acceptable for middle-class women since it implied a rejection of their maternal duties. Many

of the women who did attend, however, did not reject their domestic responsibilities, but merely wished to extend those capabilities into the public sphere (Marks and Gaffield, 1985). It was upon this basis that single middle-class women justified their employment as nursing superintendents.

WOMEN AND WAGE LABOUR⁸

Employment for women are related to broader structural and ideological changes. But how did their occupational distribution change?

As previously noted, independent commodity production prevailed in mid-nineteenth century Ontario; wage labour was not widespread. Some working-class women were undoubtedly employed (Light and Prentice, 1980), mostly young, single and lower-class, although some middle-aged lower-class women were also known to have been employed in hospitals (Angus, 1973). However, it is difficult to ascertain on what scale women were employed.

Reflecting the lack of occupational diversity in general, in addition to other factors, women were limited to a small number of occupations. Employment in domestic labour was most common (Leslie, 1974), while the textile and clothing trades (Johnson, 1982; Steedman, 1986) and urban factories (Katz, 1975) emerged as work alternatives for women. Owing to the small number of hospitals, and a

tendency to rely on its inmates to do the daily labour, few women worked in them.

Existing evidence suggests that women were paid considerably less than men (Katz, Doucet and Stern, 1982; Trofimenkoff, 1981). Katz (1975) and Gagan (1981) even argue that the low wages made marriage a necessity for economic survival. Wages in nursing were also low, although the requirement that the female workers reside in the hospital saved the costs of room and board. However, as a consequence of the low wages and the oppressive conditions in nursing residences, many women left nursing for marriage.

It is with the growth of commercial and industrial production, as well as the subsequent changes in the family during the last half of the nineteenth century in Ontario, that women's (and men's) visible employment expanded. Excepting a few single women who had rejected domesticity in favour of fulfillment through work (Vicinus, 1985), the increasing increasing reliance on wage labour was less significant for middle-class women, at least insofar as those changes forced them to seek work. Furthermore, since agricultural production still predominated, rural women were largely excluded from wage labour because of their continuing role in household production. It was still young, single lower-class urban (Cross and Kealey, 1982; Katz, 1975) and rural (Ball, 1975; Gagan, 1981) women that

were employed outside the home.

Domestic service remained the largest single employer of women at the close of the nineteenth century (Leslie, 1974), although the oppressive conditions of domestic service forced many to seek alternative work (Wilson, 1982). Tilly and Scott (1982) argue that women's ability to leave domestic labour for other employment varied regionally owing to the uneven nature of economic growth. Nonetheless, women's increasing employment in textile, clothing, footwear, tobacco and food processing plants (Johnson, 1974; Katz, 1975) accompanied industrial growth. Further, as the number of schools and hospitals expanded, so did women's employment in teaching and nursing. While limited to primary educational streams, by the 1880's women dominated the teaching ranks (Wilson, 1982). Nurses, on the other hand, did not comprise a significant proportion of employed female workers. In 1891 only 1162 (Coburn, 1974) out of a total of 95,612 employed women in Ontario (Dominion Bureau of Statistics, 1939), 1.2 percent, were nurses. Additionally, despite their increasing employment, women's wages remained significantly lower than men's (Phillips and Phillips, 1983).

Labour force participation (LFP) rates increased for females in the early-twentieth century (Chen and Regan, 1985), from 11.87 per cent in 1891 to 18.25 per cent in 1931. That of males, though, remained much greater,

fluctuating slightly between 77.33 per cent in 1891 and 77.00 per cent in 1931 (See Table 2). The First World War did not notably change women's LFP rates, or the kinds of work in which they were employed for that matter (Ramkhalwansingh, 1974); in fact, the Ontario Commission on Unemployment noted that, owing to the recession from 1914 to 1915, and the delay in recruitment for the war effort until 1917, many women, including large numbers of nurses, were unemployed.

TABLE 2:
PERCENTAGE OF POPULATION TEN YEARS AND OVER IN GAINFUL
OCCUPATIONS, BY SEX, FOR ONTARIO, 1891-1931.

Province and Year	Percent Gainfully Employed		
	Total	Male	Female
Ontario			
1891	44.94	77.33	11.87
1901	43.63	74.50	12.60
1911	49.11	80.15	15.89
1921	48.12	78.70	16.95
1931	48.23	77.00	18.25

Source: Dominion Bureau of Statistics, Canada
Occupational Trends in Canada, 1891-1931, Ottawa, 1939.

While the increase in LFP rates for women is important, so too is the shift in their occupational distribution (See Table 3). Despite growth in manufacturing, women's employment in it declined. In 1891 33.72 per cent of women were employed in manufacturing, while in 1931 only 17.00 per cent were. As well, the percentage of women in service work decreased, although

Women's employment in nursing increased. On the other hand, the percentage of women employed in professional and clerical work expanded slightly, and by 1921 clerical work had replaced domestic service as the leading employer of females (Wilson, 1982; See Lowe, 1986, Lowe, 1982).

TABLE 3:
PERCENT OF FEMALES GAINFULLY EMPLOYED,
TEN YEARS OF AGE AND OVER, IN EACH OCCUPATIONAL GROUP,
ONTARIO, 1891-1931.

Occupation	Year				
	1891	1901	1911	1921	1931
Agriculture	5.76	3.59	3.67	2.75	2.68
Fishing,					
Trapping	0.01	0.01	0.06	*	0.08
Logging	-	-	-	-	-
Mining,					
Quarrying	-	*	-	*	*
Manufacturing	33.72	31.08	29.39	20.55	17.00
Construction	0.05		0.01	0.03	0.03
Transportation	0.55		1.57	3.46	2.99
Railways	-	4.63	0.01	0.02	*
Roads	-		*	0.01	0.01
Trade, Finance	3.82		9.01	10.96	9.18
Service	53.48	53.64	44.94	39.45	46.05
Professional	9.43	-	11.02	15.88	15.49
Clerical	2.11	7.00	11.26	22.46	28.81
Labourers	0.46	0.03	0.09	0.18	0.12
Other, not elsewhere stated	0.05	0.02	-	0.21	0.07

* Less than 0.005 percent

Source: Dominion Bureau of Statistics, Occupational Trends in Canada, 1891-1931. Ottawa, 1939.

As indicated earlier, World War I had not changed the kinds of work women did, as they were limited primarily to

clerical and light industrial work (Ramkhalwansingh, 1974). While displacing males in clerical work, women were paid only 50 to 70 percent of the former's wage, a gap also observed in other occupations as well (Phillips and Phillips, 1983; Wilson, 1982).⁹ Thus, by the 1920's nursing was only one of a wider range of alternative jobs in which women could seek employment.

SUMMARY

Briefly, the development of nursing and women's employment in it must be seen as a product of prolonged and uneven structural and ideological change. The process of commodification altered not only the economic structure of society in Ontario between 1950 and 1922, and hence also the occupational alternatives available to those who sought employment, but also the manner in which families could meet their reproductive needs. Families became increasingly reliant upon wage labour and institutional forms of care, although there were important differences between classes, and urban and rural areas. One also observes an ideological shift, from the individualistic social Darwinism of the mid to late-nineteenth century that rejected state involvement in the care of the morally deficient sick-poor, to a more collectivist social Darwinism that saw the state as an important vehicle for social reform. Further, the image of poverty as a moral condition prevailed, and support for

conservative and gradual, versus radical and revolutionary, social change remained.

Women's relationship to the family and labour market also changed. As the family lost some of its previous functions and came to be seen primarily as the locus for childcare, women's role was redefined in terms of childcare and personal service to the husband. This ideology had class-specific effects, contrasting with the necessity and reality of urban and rural lower-class women's expanding employment. Interestingly, this conflict between reality and ideology provided middle-class women with an opportunity to seek work, although in what was more "suited" to their class position. Moreover, when women of both classes sought or were forced to seek employment it was primarily limited to "women's" work - and nursing was prototypically women's work.

In order to understand more fully the employment of lower and middle-class women in nursing and the changes in the labour process of nursing it will be necessary to elaborate upon the emergence of institutionalized health care in more detail, while placing the roles of the medical profession and "professional" hospital administrators within that process. This will be the focus of the next chapter.

CHAPTER 4: NURSING AND THE INSTITUTIONALIZATION OF HEALTH CARE

We have seen that women's family and wage labour roles in Ontario were a product of broader processes of social and economic change. While these factors are relevant to the following analysis, it will be argued that, as far as the development of nursing and the labour process are concerned, one must consider in more detail the institutionalization of health care, the concomitant shift to middle-class clientele, the expanding influence of the medical profession, and later also the emergence of middle-class nursing superintendents and "professional" hospital administrators.

THE INSTITUTIONALIZATION OF HEALTH CARE

In the predominantly agrarian Upper Canada of the early to mid-nineteenth century, female lay-healers and midwives served as an important source of health care (Bull, 1934; Herrington, 1915). Health care was not widely sought from physicians or through hospitals for a number of reasons. Medical practitioners, mostly ex-military barber surgeons (Godfrey, 1979; Torrance, 1981), were uncommon, located in urban centers (Angus, 1973) and away from the majority of the population. Even if individuals wished to engage a physician's help, the cost of summoning one from the city, or travelling to the city to seek one out, was

often financially prohibitive (Chappell et al., 1956). Physician's care was also largely ineffective and even life-threatening, as they relied heavily on the use alcohol (Clarke, 1913), patent medications when available (Torrance, 1981), and on more dangerous invasive treatments such as bloodletting, purging and blistering (Godfrey, 1979; Hamowy, 1984). As a result, many individuals were rightfully suspicious of their treatments (Angus, 1973; Glazebrook, 1968). Further, there existed no tradition of reliance on physicians in health care matters to support such a practice.

Hospitals were also not widely used because they were uncommon, generally inaccessible to the rural population since they were located in the major urban centers, and perceived as impersonal institutions, compared to the intimate milieu of the home (Chappell et al., 1956). Further, and perhaps most importantly, a middle-class public had not accepted them as a source for health care. Runnalls (1974) indicates that the proposal and eventual construction of a hospital in St. Catharines met considerable public resistance in the early 1870's, a reaction that Godfrey (1979) suggests was widespread. The middle-class citizenry, the main contributors to the maintenance of such charitable institutions, argued that the sick-poor, who were perceived as the intended clientele for these institutions, would be better served through the

continued reliance upon the poor-house and other charitable organizations (Hofstadter, 1955). Further, most communities had few resources to support institutional forms of care, and so opposed hospital construction on that basis as well (Splane, 1965).

Together these factors made it easier, probably safer, and more publicly acceptable to rely on the resources traditionally available within the community. Thus, in the largely rural Upper Canada of the mid-nineteenth century, social problems such as health care and poverty were seen as a "natural" concern of the family, community, church and lay organizations (Meilicke and Storch, 1980; Splane, 1965).

The public view of illness and poverty requires some elaboration at this point because these perceptions are reflected in efforts to deal with the sick-poor, and hence also in the institutionalization of health care. As indicated earlier, an individualistic social Darwinism characterized mid to late-nineteenth century Ontario. Among its tenets was the belief that each (male) person was inherently capable of success (Gagan, 1981). One key to that success was the family, which instructed children with the "proper" middle-class moral values. One such set of values included the work ethic, which would enable a prosperous existence, and ultimately result in the "survival of the fittest", namely the middle-class. The

survival of the middle class was seen as human progress, but also implied moral progress since it meant the perpetuation and diffusion of middle-class values. By deduction, then, the sick-poor were failures, not only financially but morally (Hofstadter, 1955). The middle-class explained this as a product of their family environment, which was not conducive to inculcating middle-class values and was thus ineffective and potentially dangerous in view of the growing numbers of indigent, sick working-class in the cities. It is within this context that one can understand the emerging middle-class concern with social reform of the family (Sutherland, 1976), and the orientation of hospitals to the moral and physical needs of its sick-poor clientele.

This ideology also rejected state supported care of the sick-poor. State involvement was not appropriate because it interfered with the "~~natural~~" processes of evolutionary adaptation, both by potentially restricting an individual's pursuit of success, and by maintaining a segment of the population that, in terms of social evolution, was seen as socially and morally unfit (Hofstadter, 1955). If these individuals were to be cared for, it would have to be done through charitable means, although Spencer maintained that even charity was unacceptable since it maintained an unfit population. In such an atmosphere it is unlikely that a wide range of

comprehensive social welfare institutions could have been publicly or politically justifiable, or even economically supported for that matter.

Only five public general hospitals existed in Ontario prior to 1850 (The Hospitals Division of the Department of Health, 1934), and were maintained largely through the initiatives of public philanthropy and church contributions,¹ in which married middle-class women were often instrumental (Chappell et al., 1956; Heffernan, 1935; Heney, 1943). While some government support was apparent by the mid-nineteenth century, it was largely inadequate and unsystematic (Splane, 1965), a not unusual situation given the minimal state involvement in matters of social welfare during the period (Wallace, 1980).

These few hospitals were staffed by young and middle-aged single lower-class women who were not trained as nurses (Gibbon and Mathewson, 1947), but frequently also by female residents, the sick-poor themselves (Angus, 1973). Physicians did not play an important role in hospitals during the mid-nineteenth century, practicing only infrequently within them as a charitable gesture to the sick-poor. It was private practice that constituted their source of earnings as physicians, although it was often meager and frequently supplemented by other work (Godfrey, 1979).

As charitable institutions, these early hospitals

were administered by a voluntarily constituted board of trustees consisting of prominent local (male) citizens and businessmen. Katz (1975) suggests they were involved mainly because of the prestige with which charitable activities were accorded. Day-to-day management of the institution, though, was a function of its (female) matron, who was frequently also responsible for domestic tasks within the hospital (Angus, 1973). The uncertainty of relying upon charitable donations, as well as the ad hoc implementation of policies, which seemingly constituted "non-management", often left hospitals in what Cosbie (1975) describes as a state of perpetual debt. The centralization and bureaucratization of administration in capitalist industries had not yet begun to influence hospital management significantly, probably because, as charitable organizations, they were not accountable to anyone.

Commercial capitalist development in Ontario following the mid-nineteenth century brought important social and ideological changes regarding the acceptability and growth of institutional forms of care. Capitalist development further eliminated traditional ways of caring for dependents, and created new categories of dependents, individuals defined out of the paid labour force (Braverman, 1974). Families, then, became increasingly unable to care for their sick (MacEachern, 1922), thereby

forcing a greater reliance upon institutional forms of health care (Angus, 1973). Further, this reliance was accentuated by new forms of health problems industrial production created which could not be treated satisfactorily in the home, namely accident victims. The middle-class concern regarding social reform was intensified by the continuing growth in the numbers of sick-poor. In recognizing that state responsibility in poor-relief (Sutherland, 1976) and health care (Russell, 1951; Wallace, 1980) was required, the middle-class abandoned the individualistic social Darwinist ideology. This did not mean that poverty and ill health were no longer moral problems, but merely that society now had a collective responsibility in helping those individuals deal with their afflictions.

Demand for institutional forms of care came from one other source as well, the epidemics resulting from immigration. The large-scale influx of malnourished immigrants in overcrowded and unsanitary ships throughout the period brought frequent, devastating epidemics of cholera, smallpox and typhoid to Upper Canada (Cosbie, 1975; Gibbon and Mathewson, 1947). Epidemics, and the fear they generated among the general populous, served as a further impetus for the institutionalization of health care by requiring victims' isolation from the unaffected public (Bilson, 1984; Splane, 1965). Thus, the processes of

commodification, the middle-class ideological shift and the epidemics resulting from large-scale immigration increased the demand for and growth of institutionally-based health care.

It was not until the passage of the British North America Act in 1867, which allocated responsibility for health care to the provinces, that the state intervened in matters of health care (See Appendix A). Despite its emerging role in health care, the state's involvement was unsystematic, sporadic and on a crisis management basis (The Hospitals Division of the Department of Health, 1934; Splane, 1965), and limited largely to funding. Owing to the unsystematic and inadequate nature of the province's (and municipalities') financial contributions, and the difficulties in securing charitable funds, hospital development and expansion was often slowed or delayed (Angus, 1973; Chappell et al., 1956; Cosbie, 1975; Heffernan, 1935).

The recommendations of a commissioned report in 1872 increased provincial funding to enable hospital expansion in Ontario. The enactment of Langmuir's recommendations² in the 1874 Charity Aid Act aided hospital expansion for a short period. Between 1871 and 1881 twelve new public hospitals were built (Table 4), not to mention expansions of existing institutions. However, the growing burden of hospital funding led the province to amend the 1874 Act,

and in 1895 it decreased hospital grants (The Hospitals Division of the Department of Health, 1934).

These amendments had two significant effects: they prolonged the inadequate funding to hospitals, and differentiated between long-term "incurable" patients and shorter-term patients capable of returning to the labor force. By reducing financial aid the 1895 amendments maintained many hospitals in a state of financial peril (Editor, 1907; Ontario Hospital Association, 1902; Wilson, 1900). It was only through the efforts of administrators and physicians that the Ontario Government reconsidered its changes and increased funding in 1897 (The Hospitals Division of the Department of Health, 1934). The other notable effect of the 1895 amendments was to "encourage" public hospitals to restrict the lengths of stay of its patients (Angus, 1973). One of the measures included in the amendments limited per diem payments for patient stays to a maximum of 120 days. Since this affected predominantly the sick-poor, the amendment effectively distinguished short-term "curable" patients from long-term "incurables". The St. Catharines General and Marine Hospital, for example, stipulated in its regulations that no patient was to be admitted unless curable (Runnalls, 1974). Further, by affecting mostly the sick-poor, the restrictions placed on the length of hospital stay lessened the emphasis on "moral" care and served as a means of ridding the hospital

of malingerers, that is, individuals who because of their alleged deficient moral character were dependent upon charity.

TABLE 4:

Public Hospitals: Number of Hospitals, and Number of Patients Treated, Ontario, Decennial Years, 1871-1891, Quinquennial Years, 1900-1930.^a

Year	Number of Hospitals	Patients Treated ^b		
		Number	No. per Thousand Population	Average Days Patient Treated
1871	9	-	-	-
1881	21	-	-	-
1891	39	-	-	-
1900	51	29,572	14	24.5
1905	56	37,736	16	20.1
1910	70	52,321	21	19.2
1915	80	82,690	30	17.7
1920	90	130,382	46	14.9
1925	118	152,102	49	14.0
1930	139	218,753	65	13.7

^a Data from 1900-1930 include only public general hospitals, but not special and unclassified hospitals, or convalescent hospitals, and homes for incurables. A public hospital is defined as one which is not operated for profit, and accepts all patients regardless of ability to pay.

^b Based upon the total number of patients treated and not patients discharged.

Sources: Urruhart, M.C. (ed.) Historical Statistics of Canada, 1965, p.51.; Census of Canada, 1870-71, Volume II, Ottawa, 1873; Census of Canada, 1880-81, Volume II, Ottawa, 1884; Census of Canada, 1891, Volume IV, Ottawa, 1893; Census of Canada, 1901, Volume IV, Ottawa, 1906.

By abandoning the emphasis on the moral and physical care of the sick-poor, as Shortt (1983-1984) contends, the

hospital was able to change its image and attract middle-class patients. Additionally, though, Cosbie (1975) points out that middle-class patients were reluctant to use hospitals until the epidemics had subsided, since hospitals constituted the focal point of efforts to deal with its consequences, and witnessed high mortality rates even among staff.

TABLE 5:
Public General Hospitals:^a Percent Distribution of
Income, Ontario, Quinquennial Years, 1900-1930.

Percent Distribution of Income				
Year	Patients	Donations and Bequests	Municipal Grants	Provincial Grants
1900	35.3	26.4	16.4	18.3
1905	48.6	15.5	18.4	12.7
1910	51.7	13.4	20.1	10.6
1915	51.2	7.5	30.0	7.9
1920	64.8	9.5	17.6	6.1
1925	64.3	7.6	16.9	9.0
1930	67.0	7.1	15.6	8.2

^a Does not include special or unclassified hospitals. Also excludes convalescent hospitals and homes for incurables. A public hospital is defined as one which is not operated for profit, and accepts all patients regardless of ability to pay.

^b Does not include per diem grants by provincial or municipal governments to hospitals.

Source: Urquhart, M.C. (ed.) Historical Statistics of Canada, 1965, p.51.

In some Ontario hospitals by the end of the nineteenth century, the number of paying patients had grown (Angus, 1973; Cosbie, 1975; Runnalls, 1974), indicating

that the hospital had become a publicly acceptable site for health care delivery. Moreover, the importance of paying patients to the financial welfare of the hospital is emphasized by the efforts of hospital administrators to further restrict the number of charity patients accommodated so that more paying patients should be admitted (Angus, 1973; Cosbie, 1975; See Table 5). By 1900 payments from patients had grown to 35.3 per cent of hospital income in Ontario, while donations and bequests comprised only 26.4 per cent. The addition of private rooms was even suggested by administrators when financial circumstances became desperate, although this policy was not always successful (Runnalls, 1974).

Thus, beginning in the last quarter of the nineteenth century hospital-based health care delivery in Ontario expanded, in terms of the number of hospitals as well as the number of patients, both absolutely and relatively. Between 1871 and 1900 the number of public general hospitals increased from 9 to 51. Similarly the number of patients grew to 29,572 in 1900, and the rate of hospitalization per thousand population reached 14 in the same year. This growth, though, implied some expansion in the nursing ranks. The number of nurses did increase, frequently in close association with an expansion in hospital size, although not proportionately (Angus, 1973; Runnalls, 1974; Table 6). While existing data regarding the

number of nurses is inadequate, the census records that the number of nurses almost tripled between 1881 and 1891 in Ontario, suggesting that by the end of the century the number of nurses was increasing rapidly. Further, while middle-aged and untrained nurses were still being hired by hospitals up to the late 1870's, the development of training schools for nurses in the 1880's increased the proportion of young, single rural and urban lower-class women in the hospitals, now as student-workers. An expansion in the number of nursing staff within the hospital also necessitated increasing the number of staff required to coordinate and control their work, a function delegated to single, middle-class (female) nursing superintendents.

The employment of nursing superintendents in the hospital beginning in latter part of the nineteenth century requires some comment at this point, since they played a significant role in nursing reform. As pointed out previously, some single middle-class women sought fulfillment through work. However, they did not reject entirely the predominant ideology regarding women's social roles. Maternal feminism held that women's allegedly inherent caring and moral capacities should be applied in the public sphere (Vicinus, 1985), and nursing presented just such an opportunity, albeit in administrative positions. Ward nursing in Ontario was not a suitable

occupation for middle-class women, since it was comprised of domestic labour, for which the middle-class hired servants, and required extensive contact with morally "deficient" lower-class and male patients.

TABLE 6:
Number of physicians, nurses, and midwives, Ontario,
1851-1930.^a

Year	Physicians	Nurses	Midwives
1851	410	-	8
1861	603	-	16
1871	1565	-	21
1881	1778	359 ^b	61
1891	2266	1162 ^b	-
1901	-	-	-
1911	3053	2763	-
1921	3459	9951	-
1931	3860	13664 ^c	-

^a These figures only include those registered practitioners. They do not include those untrained or irregular practitioners. The figures for midwives include only those women trained in other countries that moved to Canada to continue their practice.

^b Figures include midwives and nurses.

^c Figure combines graduate nurses (8,689) and nurses in training (4,975). The sources utilized do not indicate if data for earlier years also included student nurses.

Sources: Coburn, Judi "I See and am Silent: A Short History of Nursing in Ontario.", 1974; Census of Canada, 1870-71, Volume II, Ottawa, 1873; Census of Canada, 1880-81, Volume II, Ottawa, 1884; Census of Canada, 1891, Volume II, Ottawa, 1893; Census of Canada, 1911, Volume IV, Ottawa, 1915; Census of Canada, 1921, Volume IV, Ottawa, 1929; Seventh Census of Canada, 1931, Volume VII, Ottawa, 1936.

Until the number of training schools increased during the late-nineteenth century in Ontario, most nursing

superintendents were untrained as nurses, although still better educated than their lower-class counterparts. Middle-class women were hired as nursing superintendents because of their alleged superior morality (Vicinus, 1985). They were to be "loyal, pure in thought and life, patient ...[control themselves] in the most trying circumstances" (McNeill, 1910:110), and above all, to know their place. These expectations were reflected in the hiring of Miss Goldie as the first nursing superintendent at the Toronto General Hospital. Although without hospital experience, her hiring was justified because she was a "woman of culture and refinement" (cited in Clarke, 1913:91). Further, it was upon their middle-class morality which nursing superintendents based their attempts to make nursing a respectable occupation for other middle-class women. However, a number of factors intervened to render their strategies ineffective (See Chapter 6 and 7).

Hospital-based care, developed most swiftly in urban centers (Splane, 1965), a pattern that had important consequences for the medical profession's ability to control the practice of alternative practitioners and hospital administrators' ability to secure a domain of influence. In areas where physicians were not prominent alternative female practitioners continued to flourish (Biggs, 1983). Physicians could not control their practice until some time after the hospital had been well

established as the primary site for health care in rural communities, medical practice had become "scientized", and the medical profession succeeded in securing a legal monopoly. The emergence of "professional" hospital administrators, on the other hand, was associated with an expansion in the scale of institutionalized care, which occurred first in urban settings. Nurses and physicians continued to administer hospitals in the smaller rural and urban institutions.

THE MONOPOLIZATION AND "SCIENTIZATION" OF MEDICAL PRACTICE

The medical profession's success in creating a legal monopoly and exercising control over the other practitioners was predicated upon state legitimation. But for a monopoly on medical practice the profession also needed to convince the paying public of its superiority vis-a-vis other practitioners (Larson, 1977). It is through the increasing scientific content of medical practice, the "scientization" of medicine, that regulars sought to justify their claim to superiority (see Vogel and Rosenberg, 1979).

Attempts to license and hence monopolize medical practice in Upper Canada began in 1795, although efforts continued to fail until 1865 (MacNab, 1970; See Appendix B). Licensing legislation was hindered by a number of factors, including public opposition to a monopoly on

medical care, resistance from homeopaths and other irregular practitioners, and factionalism among allopaths (Gidney and Millar, 1984; Hamowy, 1984). Regular physicians were unable to overcome these difficulties until 1865, despite their favourable connections with socially, economically and politically dominant groups (Hamowy, 1984; Torrance, 1981). While the 1865 Ontario Medical Act technically restricted medical practice to licensed physicians, it was not until the 1869 act eliminated discrepancies in education and licensing between regulars and irregulars (homeopaths and eclectics) that this monopoly actually became enforceable (Gidney and Millar, 1984). The 1869 Act allowed the medical profession to more effectively suppress "quacks" and irregular practitioners and increase their control over the practice of other health care occupations, including nursing, although it continued to experience difficulties in realizing this potential (Hamowy, 1984).

But this legal monopoly could not enforce that sick people should only see regular physicians. Female lay-healers, midwives and other alternative practitioners practiced even after the 1869 Ontario Medical Act (Biggs, 1983; Hamowy, 1984). Further, the practice of regular physicians was essentially trial and error, and hence provided little support for claims to superiority since their treatments were no more effective than those of any

other practitioners. In fact, Larson (1977) suggests that the milder forms of therapy espoused by homeopaths were considerably less dangerous than those of the regulars. Regulars, though, sought to differentiate and distance themselves from irregulars and other non-physician practitioners in order to legitimate their control over medical services, and science presented that opportunity.

A number of scientific developments, including the microscope, germ theory of disease (Boyd, 1909), and X-Rays, were taken by physicians to represent the increasing sophistication of medical care. These claims were also important in consolidating the profession's control over health care, and hence in strengthening their superordinate status. But the scientization of medicine was associated with other similarly broad changes.

Habermas (1970) links the rationalization of society to the institutionalization of scientific/technical development, of which the institutionalization of medical practice is but one component. He argues that the significant increase in productive capacity occurring with capitalist development, and the subsequent increase in social prosperity legitimated the institutionalization of scientific/technical development: thus the association of progress, science and capitalism. This legitimation, however, obscured the domination it imposed,³ and precluded public control over the direction of scientific development

because of its highly technical and hence, publicly inaccessible content (knowledge). In effect, scientific-technical rationality became self-propelling and self-legitimizing.

Scientific knowledge and its subsequent application require a reasonably standardized educational context within which they can be disseminated. While the 1865 Ontario Medical Act established a General Council of Medical Education and Registration which had as a goal the standardization of medical education, there was at that time no consensus among physicians that the university should be the focal point of medical education. Many medical practitioners fought against medical educators to increase the amount of clinical (apprenticeship) training (Mullin and Routley, 1921; Wright and Cameron, 1882a).⁴ Nonetheless, by the end of the nineteenth century the universities had gained control over medical education, thereby standardizing medical education (Godfrey, 1979; MacNab, 1970) and consolidating science as the basis for medical practice (Gidney and Millar, 1984; Roland, 1980).

These changes collectively had significant influences upon nursing. The physicians' claims that science had made its practice more successful, in addition to the standardization of university-based medical education, legitimated its control over medical practice, at least in their own minds. By deduction, nurses, female lay-healers

and midwives could not practice medicine since their practice was not scientifically based.⁵ Perhaps most importantly, the legal monopoly on medical practice restricted the boundaries of nursing practice since nurses were now legally bound to follow doctor's orders. The interests of nurses and nursing superintendents were further subordinated because of the power physicians wielded within the hospital by virtue of their control over patient care. Hospital administrators informally acknowledged, and even formally codified the primacy of the physician in hospital operations.⁶ This, however, is not to say that physicians had total control within the hospitals, for a group of non-physician "professional" hospital administrators emerged whose managerial objectives brought them into conflict not only with physicians' interests in advancing medical practice, but also with those of nursing superintendents in reforming nursing.

THE EMERGENCE OF "PROFESSIONAL" HOSPITAL ADMINISTRATORS

At mid-century Ontario hospitals were managed, or non-managed, by a voluntarily constituted board of trustees, with day-to-day operations in the hands of matrons. The incorporation of hospitals, beginning in the 1860's and reflecting a felt need to more effectively manage hospitals, disbanded the volunteer boards and created boards of governors that were left with the final

responsibility for hospital operations (Angus, 1973). Administration, though, remained a function of nursing superintendents, at least in the rural and smaller urban institutions (Cosbie, 1975; Runnalls, 1974), while in larger urban centers physicians and lay persons retained that function (Agnew, 1974; Robertson, 1908). Nonetheless, evidence suggests that unsystematic and unplanned management persisted (Angus, 1973; Cosbie, 1975). Hospital administrators were apparently not yet taking the lead of their counterparts in industry and rationalizing management (cf. Reverby, 1982), that is, centralizing and bureaucratizing administration. Again, the hospital's status as a charitable institution did not expose it to the pressures of generating surplus value, although it was expected that ~~they~~ would meet part of their expenses.

By the end of the nineteenth century urban hospitals had undergone considerable change. They were larger, treated more patients, had more medical and nursing personnel, and were increasingly specialized in terms of the services they offered (Angus, 1973; Cosbie, 1975). Hospital funding also changed notably. As provincial and charitable contributions declined, the proportion of income from municipalities and paying patients increased. However, since hospitals seemed to exist in a state of perpetual debt (Angus, 1973; Cosbie, 1975), securing adequate funding must have continued to be a major difficulty,⁷ with only a

rare exception (cf. Runnalls, 1974). Administrators, then, were forced to recognize the need to rationalize hospital management practices (Editor, 1907; Smith, 1907).

Coordination and control of the workers within the hospital also became more problematic with hospital expansion, the emergence of nurses training schools, and the advancement of medical practice. Physicians resented the influence nursing superintendents had upon hospital operations (see Angus, 1974; Cosbie, 1975), although by this time nursing superintendent's role was limited largely to nursing functions in the larger urban institutions. The rapidly increasing costs of scientifically-based medical practice strained the relationship between administrators and physicians as the objectives of medical practice and sound financial administration became increasingly opposed (Decker, 1923).

Moreover, World War I created additional problems for hospital administrators in Ontario, since large numbers of physicians and nurses had enlisted (Gunn, 1918; Ink, 1919), the demand for hospital care increased, and hospital funds were restricted (MacPhail, 1914). These developments strained hospitals' ability to cope, thus forcing many administrators to restrict hospital services or close the institution altogether. Together, these changes forced hospital administrators to realize the importance of sound financial management and the more effective coordination of

hospital activities, and also served as an impetus for "professional" administrators to create their own sphere of influence within the hospital.

Thus, while the roles of administrators and physicians became increasingly differentiated, control over nursing practice remained a domain of struggle between administrators, physicians and nursing leaders.

SUMMARY

I have argued that between 1850 and 1922 in Ontario the transition from a reliance upon the self, family and community in health care to institutionally oriented health care and the consequent emphasis on the moral and physical "needs" of the sick-poor, supported the creation of a specialized occupational group to care for those patients, namely nurses. The institutionalization of health care was precipitated by an increasing dependency and an erosion of traditional forms of care, and to which epidemics among immigrants also contributed. The growth of institutional forms of care, while requiring increased funding, was also supported by the shift toward a middle-class clientele and the emergence of training schools for nurses to staff the hospitals.

The transition to hospital-based health care was also influenced by regular physician's efforts during the nineteenth century to delineate, create and control a

market for their services. Their medical monopoly was legally supported by the state but also, through the scientization of medical practice, at least in physicians' eyes. By the turn of the century physicians had gained a wide influence within the hospital through their control over patient care, and hence also over the content of nursing practice, although they had begun to lose administrative control within the institution to "professional" hospital administrators.

Hospital management underwent significant changes during this period, in terms of both administrative procedures and personnel. It was only at the turn of the century that a specialized group of administrators displaced physicians and nursing superintendents in that role, and hospital management became more centralized and bureaucratized, although primarily in the larger urban settings.

While physicians and administrators struggled for dominance in their fields, by the late-nineteenth century a group of middle-class nursing superintendents, later nursing leaders, sought to establish nursing's legitimacy as an acceptable occupation for middle-class women. Efforts to reform nursing were shaped by the moral focus of nursing superintendents, as well as the potential influences of physicians and administrators in shaping the content of nursing education and practice. It is toward the historical

changes in control over the nursing labour process which I
will now turn.

PART III

NURSING AND THE LABOUR PROCESS:
THE INSTITUTIONALIZATION OF HEALTH CARE

CHAPTER 5 HOUSEKEEPERS' AND DOMESTICS

The transition from independent commodity production to wage dependency during the mid to late-nineteenth century in Ontario represented a significant shift in the relations of production, namely the formal, and later real subordination of labour to capital. While the concepts will not here be directly applied (see Chapter 2), they are useful in orienting the analysis of the nursing labour process towards the division of labour, systems of control, the organization of work and work skill. In this chapter, then, I will examine how the broader structural and ideological conditions that shaped institutionalized health care prior to the emergence of training schools for nurses, affected the development of nursing, and hence also the labour process.

NURSING MOVES INTO THE HOSPITAL: "DOMESTIC SERVICE"

The growth of hospital-based health care during the mid-nineteenth century in Upper Canada, resulting from factors previously outlined, required the introduction of personnel to staff hospitals. The institutions' precarious financial position, since they were reliant upon charity, infrequent paying patients, and unsystematic government grants, necessitated the purchase of cheap labour power. In order to remain financially viable, or perhaps even

profitable as only a few institutions were (Runnalls, 1974), hospital trustees simply could not afford to pay high wages. The payment of low wages for work that was frequently onerous, coupled with the requirement that nurses live in the hospital, made it possible for hospitals to rely on the labour power of unskilled, single workers from the lower-class, most of whom had little education and no training as nurses (Campbell, 1984; Macbeth, 1959; Shepherd, 1906, Snively, 1905a). The unskilled and cheap nature of their labour power, though, is not sufficient to explain why it was that women were drawn into this work.

The relative lack of alternative employment opportunities for women during the mid-nineteenth century drew them to accept employment in the hospitals. The viability of this alternative though, was accentuated by the hospitals' residency requirement (Street, 1973), which "saved" them the expenses of board and room, a very real concern of urban lower-class and rural women during the period since they were generally unable to afford independent living arrangements (Gagan, 1981; Katz, 1975).

More importantly, however, were the ideological influences upon women's employment in mid-nineteenth century Ontario. Firstly, women's employment was held to be of secondary importance; their primary duty was childbearing and rearing. Employers also assumed that women's work, such as in the hospital, was, or should be,

an extension of their domestic responsibilities in the home (Freidson, 1970). Further, social sentiment associated women with helping the ill (Hunter, 1905), which only reinforced the link between women and nursing. It should not be surprising to note that many, like MacDermot, a physician, mused that "these women...must have had a natural instinct for nursing" (MacDermot, 1940:5).

While motherhood and domestic labour were considered an honourable occupation for women, these early nurses and their work were held in contempt (Coburn, 1974), and lived in conditions of squalor. A physician relates that,

Age and frowsiness seemed the chief attributes of the nurse, who was ill-educated and was often made more unattractive by the vinous odour of her breath. Cleanliness was not a feature, either of the nurse, ward or the patient; the language was painful and free...Armies of rats frequently disported themselves about the wards and picked up scraps left by the patients and sometimes attacked the patients themselves" (Gibbon and Mathewson, 1947:146).

Likewise, Dr Clarke states that

the women who acted as nurses were too often crude, uneducated, and not unfrequently, alcoholic in their habits. Cleanliness was not a sine qua non, the pay was a mere pittance, and the work was...repulsive and hopeless... (Clarke, 1913:91).

Ashley (1976) discounted the pervasive Dickensian image of nurses and nursing during the period, but there is undoubtedly some truth to these assessments. Chen and Regan (1985) argue that census categories reflect social perceptions concerning the utility and value of particular occupations. That nursing was not a census category until

1881, and even then midwives were included, suggests that not only did few "nurses" exist, but the work of nursing was not well differentiated from domestic labour and not held in especially high social esteem.

More importantly, though, is the impact of these social perceptions, however accurate they may have been. According to Dr. Clarke (1913) the low social status of nursing and the repulsive nature of their work made hospital administrators unable to attract a "better" class of women. Presumably Clarke is here referring to women with a middle-class morality and upbringing. Macbeth (1959) also notes that many parents and their daughters were opposed to their performing the menial tasks associated with nursing. Given the prevailing image of nurses and their work, and, as pointed out earlier, the predominance of sick-poor among a hospital's charges, and the public distaste for hospitals at large, it is not surprising that middle-class women did not work as ward nurses, since it was not work befitting of their social status. Moreover, these perceptions were reflected in the continuing practice of the middle and upper-classes in being treated in their own homes (Shortt, 1983-1984).

NURSING AND THE LABOUR PROCESS

As charitable institutions, hospitals in Ontario were officially the responsibility of a voluntarily constituted

board of trustees (See Chapter 4). However, the day-to-day responsibilities of overseeing nurses' work were delegated to (female) matrons, who were themselves frequently involved with the actual ward work. Since hospitals were not dependent upon their services, (Godfrey, 1979), physicians had little direct influence on hospital nursing, and, although in their occasional presence they expected some deference from nurses, little was apparent. It seems that lower-class nurses did not feel bound to the same social conventions which constrained the interactions of middle and upper-class women.¹ Further, trustees recognized that "nursing" services were more important to the hospital than were the occasional medical services (Clarke, 1913), since it was only through nurses's efforts that hospitals continued to function. Thus, while having little control over the "recruitment" of clients (patients) into the hospital, nurses faced a low division of labour and retained considerable control and autonomy over their work.

Reports suggest that nursing in these early hospitals was little more than domestic labour, consisting of cooking, cleaning and washing clothes and linen (Angus, 1973; Chappell et al., 1956). The secondary nature of patient care is apparent in Macbeth's (1959:21) observation that "stout, able-bodied" women were "engaged to do the daily work and assist with patients". In other words, patient care was not their primary responsibility. Further,

trustees considered these women as little more than domestics. The Montreal General Hospital even classified nurses as servants (MacDermot, 1940).

Thus, because nursing was unskilled domestic labour, work which any woman was inherently able to do, and since women's work was assumed to be of secondary importance to the family, trustees merely reflected social convention by paying these women low wages. Cosbie (1975) notes that in 1868 at the Toronto General Hospital nurses were paid lower wages than cooks and washerwomen.

The expansion of hospital care during the 1850's and 1860's meant change for hospitals and nursing. Hospitals grew in size, and so did their nursing labour force. Moreover, physicians demonstrated a greater attempt to move into the hospital, a reflection of their broader efforts to monopolize medical practice. While in rural and smaller urban hospitals matrons continued to administer hospital operations, in the large urban hospitals those responsibilities were now delegated to physicians (Agnew, 1974; Robertson, 1908), and more frequently local prominent citizens and businessmen (Guest, 1972; Robertson, 1908).

Despite changes in management personnel, administrative procedures had not altered significantly. Smith (1907) criticized hospital administrators for exercising a policy of non-management, an assessment supported by the experiences of many physicians who

attempted to establish a more systematic organization of medical care within the hospital (Angus, 1973). Further, matrons and now also nursing superintendents, were still responsible for supervising their nursing labour force.

It was at this point that efforts by single middle-class women to find meaningful work (Vicus, 1985) coincided with the expansion of institutional health care. The need to hire more staff to supervise the work of a growing body of nurses, and the concern for the moral welfare of the hospital's sick-poor clientele, made middle-class women's morality more attractive to trustees, resulting in a growing number of single middle-class women being employed as nursing superintendents. In rural settings and smaller urban hospitals in Ontario, these same middle-class matrons, largely untrained as nurses, although by the mid-1870's a small minority had trained in Britain or in the United States (CNA, 1968; Millman, 1969), frequently assumed control over both hospital operations and the nursing labour force (Agnew, 1974). In the larger urban hospitals, however, nursing superintendents were now often directly responsible to the Medical Officer (MacBeth, 1959).

Just as the hospital management was frequently relatively unsystematic, so too was control over patients and the nursing labour force, since it was based upon personal relations, and expectations of class and gender

appropriate behavior. Charlotte Aikens, a Canadian born nurse who became an important figure among American hospital administrators and was widely published in The Canadian Nurse, argued that strict discipline for both patients and nurses was necessary (Aikens, 1907c,d,e). Nursing supervisors believed that the unquestioning obedience of patients and nurses to their superiors (MacBeth, 1959) maintained social hierarchies that existed (or should exist) within the hospital between the staff and patients. These hierarchies were based upon class and gender.

Since it was predominantly the morally deficient sick-poor who were attended to in hospitals, superintendents felt a moral (ie. class) distinction needed to be maintained between patients and nurses in order to improve social conceptions of nurses and their work, despite the reality that the nursing staff and patients more often came from similar class locations. They were also careful to caution ward nurses about the reputed sexual proclivities of male patients (MacBeth, 1959). In fact, some objected to female nurses having to work with male patients at all because of the perceived risk of their sexually immoral behavior. Interestingly, Vicinus (1985) suggests that one of the reasons why these middle-class women remained single and entered nursing was because of their disdain for the perceived insatiable sexual appetites.

of males within marriage, in contrast to their (women's) own socially proscribed passivity.

A class difference was also notable between ward nurses and nursing superintendents. Interaction between the two categories of nurses was meant to be formal and based upon conceptions of socially appropriate behavior between individuals of differing class locations (McNichol, 1971; Street, 1973). Matrons were, after all, the moral superiors of their lower-class charges (Vicinus, 1985). The social distance between nursing superintendents and their nursing staff, for example, is reflected in the separation of dining rooms for superintendents and nurses, such as occurred in the Hospital for Sick Children in Toronto (Anonymous, 1907).

In addition, absolute, unquestioning obedience to the dictates of the higher social-class physicians was expected from lower-class nurses, middle-class matrons, (Aikens, 1907a,d) and lower-class patients, although I will argue later that this did not always occur. The hospital was based upon a patriarchal family model in which the physician/father occupied a superordinate position vis-a-vis the nurse/mother and patient/child (Ashley, 1976; Reverby, 1982). The strict obedience of nurses and matrons to the physician, then, can also be related to an ideology dictating the proper social position of women in relation to men (Cook and Mitchinson, 1976; Vicinus, 1985): that is,

subordinate.

This family model was also transposed onto the nurses' residence. As noted earlier, nurses were required to live in residence at the hospital (Angus, 1973; Campbell, 1956), it was almost a requisite given their long hours of work, never mind women's general inability to live independently. Their physical isolation within the hospital, combined with the matron's capacity as "surrogate mother" to control her labour force, even when not actually working, frequently rendered nurses existence oppressive. In some hospitals nurses had to ask permission to leave hospital grounds, faced curfews, and had mail censored, among other things. Work was commonly the only experience nurses had; a social life outside the hospital was almost non-existent.

Much of nurses' work, though, was not directly supervised, despite the control nursing matrons wielded. Macbeth (1959) notes that matrons were not required to be present constantly on the wards, but only to make regular daily inspections. In fact, while circumscribed by the physician's orders, nurses had considerable control over their work and the patient's daily activities. Nursing was comprised of domestic tasks, which included maintaining the ward in a cleanly state, assisting patients with personal hygiene, preparing and serving meals, providing the patient with prescribed medications, the applying dressings and

poultices, and, when physicians were present, catering to their needs and demands as well (MacDermot, 1940).

Consequently, work techniques were based upon tradition (Snively, 1905a), and hence not systematized or widely regulated. In effect, their employment in the hospital had not significantly changed the technical conditions of their work.

Ward nurses, though, faced an intensification of their work by hospital administrators as ~~the irregular~~ and tenuous nature of funding frequently precluded hiring additional nursing staff. Long working days were commonplace, often extending past twelve hours in one day. Nurses were also expected to work all seven days of the week, with only a half-day off on Sundays (Angus, 1973), and, in some institutions, an additional afternoon off each week (Snively, 1905b). Nurses were also subjected to high patient loads (Clarke, 1913). MacDermot (1940) notes that frequently there was only one night nurse responsible for two or three wards of patients. He also observes that the number of patients each nurse was expected to care for increased from six in 1877 to that same year. MacDermot attributes these changes to the hospital's increasing operating costs. Given the influence of economic necessity on ward staffing, it is reasonable to expect that in less financially stable institutions the conditions of nurses' work were even more oppressive.

However, while they were expected to accept the directives of their superiors, nurses' clearly responded with distaste to their work conditions (see MacDermot, 1970), although there are few references made to such actions in the literature. Nonetheless, these few examples indicate that the economically and socially motivated dictates of physicians, administrators and nursing matrons were not always passively accepted. Nonetheless, the considerable control administrators, superintendents and physicians wielded within the hospital, the expectations of class and gender appropriate behavior, and the relative absence of alternative employment opportunities for women from the 1850's to 1870's in Ontario, exerted considerable pressure upon nurses to accept the conditions which they faced in the hospital.

SUMMARY

As is apparent, women's entry into the hospital as nurses and the development of the labour process were shaped not only by the broader processes of social change, but also by changes at the level of the workplace within the health care system. Further, class and gender were operative at both levels of analysis.

The entry of lower-class women into the hospitals as poorly paid nurses in mid-nineteenth century Ontario was based not only on the economic requirements of hospitals as

charitable institutions, but also on the perception that nursing was women's work. The work these women did was composed predominantly of domestic tasks, and as a result was considered unskilled as it was "natural" for women. Little division of labour was in evidence since the women that were hired were responsible for a wide range of tasks that were apparently not differentiated by skill. Direct supervision of their work was practically non-existent, although hospital trustees and matrons could potentially exert some control over their "nursing" labour force. Such control was based upon class and gender-specific behavioral expectations, particularly as shaped by middle-class morality.

By the 1870's hospitals had begun to expand in size and number, as demands for institutional care increased. As is apparent, these changes, particularly as far as the entry of physicians and middle-class nursing superintendents into the hospital are concerned, had important consequences for nursing work. The division of labour had expanded to differentiate further between the work of nurses, physicians, nursing supervisors and administrators. This difference is important since administrative functions and those responsibilities claimed by physicians were defined as non-nursing labour. In other words, the emergence of distinctly administrative and medical functions in the hospital delimited the boundaries

of nursing practice.

Nursing work itself did not face any decomposition. It was still work that was done by a growing collection of individuals. The skill level of nursing had not changed significantly, as it was still characterized by domestic labour, although one begins to note the emergence of specifically "nursing tasks", such as dressing changes, poultice applications and bandaging. Further, control remained based upon class and gender-specific behavioral expectations, and was intensified as nursing superintendents attempted to reform the moral character of nursing as work.

The directives of administrators and physicians were not always passively accepted by nurses or their nursing superintendents. Nurses' expressed more dissatisfaction with the conditions of their work, but were limited in their capacity to induce change. More visibly, nursing superintendents translated that dissatisfaction into action as they attempted to reform nursing. The next chapter will focus on nursing leaders' efforts to reform nursing, and how those efforts affected the labour process.

PART IV

NURSING AND THE LABOUR PROCESS:
TRAINING SCHOOLS

CHAPTER 6 TRAINING SCHOOLS FOR NURSES

Training schools for nurses in Ontario, which emerged beginning in the 1870's and accompanied the expansion of hospital-based care, were significant in further subordinating nurses to hospital administrators, physicians, and nursing superintendents on the bases of social-class and gender. This chapter will deal with how the apprenticeship training system affected the development of nursing and its labour process.

THE EMERGENCE OF TRAINING SCHOOLS FOR NURSES

As medical practice in late-nineteenth century Ontario gradually became more scientific, so it was argued that nursing needed to increase its knowledge base (Ellis, 1909; Canadian Nurse, 1916). Riddell (1970) and Gibbon and Mathewson (1947) argue that training schools for nurses grew out of this "need". While this requirement can, in part, account for the introduction of nurses' training, it is not sufficient to explain the emergence of a specific form of training schools, the hospital-based apprenticeship system.

The first training school for nurses in Upper Canada began in 1874 as the Mack Training School (Hutchison, 1906). Although it was apparently modeled on Nightingale's own (Runnalls, 1974), the school for nurses that resulted

in St. Catharines differed in one crucial respect from Nightingale's. Nightingale's training school was independently endowed (Baly, 1986; Russell, 1951), because she did not want the labour demands of the hospital to dictate the course of training (Woodham-Smith, 1950). The Mack Training School for nurses, on the other hand, was an extension of the hospital, despite Dr. Mack's attempts to secure an endowment. The hospital and training school constituted a single economic unit, with the demands of the former shaping the latter.¹ Most training schools in Ontario followed this pattern, although they were organized largely by graduate nurses trained in the United States, (Gibbon and Mathewson, 1947; Millman, 1969, see Melosh, 1982; Reverb, 1982).²

Like the apprenticeship orientation of the British Guild system, the primary impetus behind training schools for nurses was not the educational betterment of its "apprentices", but economic considerations. According to Craig and MacLeod (1984) training schools for nurses were established to secure a supply of nurses for the length of the training program, which in Ontario was generally two years. This objective was recognized by administrators (Russell 1951), nursing leaders (Paffard, 1913; Street, 1973), nurses at large (Breay, 1913), and political bodies as well (Hodgins, 1918). Given the dire financial circumstances of many hospitals, the supply of labour had

to be cheap, and cheap it was. At the Hamilton General Hospital in 1891, nurses in training were paid \$4 to \$12 per month, while housemaids and cooks earned \$8, laundresses \$10, and porters \$13 per month (Campbell, 1956). In Ottawa, nurses at the Lady Stanley Institute were paid \$2 to \$10 per month (MacBeth, 1959).

The labour of student nurses was so vital to hospitals that an expansion in patient capacity was frequently associated with an increase in the size of the student body (Guelph General Hospital, n.d.; St. Joseph's General Hospital, 1958/1959). Their use, however, was not limited to "nursing". Haywood (1922) and Macbeth (1959) point out that students were also "trained" in administrative tasks, and performed a wide variety of other jobs within the hospital. Despite growing numbers of trained nurses, hospital administrators continued to rely upon the labour of its students. While their lower "cost" can be invoked to explain their preference for student nurses, there are other important reasons as well.

Coburn (1974) argued that nursing students were preferable to trained nurses because they could be socialized into the hospital routine without the student's familiarity with other hospital routines interfering with that process. In other words, students were potentially more controllable than their trained counterparts. The residency requirement and the contractual nature of the

agreement to enter the training program also created a relatively stable workforce of nursing students who could be depended upon, and who could be more easily controlled by hospital administrators than graduate nurses, who were always able to move to different employers. Further, in explaining the development of nursing in the United States, Reyerby (1982) observed that graduate nurses did not even want to work in hospitals as it limited their autonomy.

The needs of hospital administrators meshed well with those of rural and urban lower-class women during the 1870's and 1880's in Ontario. Economic necessity and the limited range of work alternatives available for women meant that many were forced to enter nursing (Mackenzie, 1910). The apprenticeship system further encouraged this possibility through its lower educational pre-requisites (Light and Parr, 1983; cf. Prentice, 1975), the provision of room and board, and payment during the training period (Chappell et al., 1956; Runnalls, 1974; St. Joseph's School of Nursing, n.d.). Despite the lack of public respect for nursing and nurses, Chesley (1909) maintains that women often chose to enter nursing as a means of social mobility. Regardless of whether nursing students were aware that nursing would itself be no guarantee of increased social standing, the hospital did present one avenue for social mobility. Other than obtaining a position as superintendent at a training school, which would have been unlikely

especially for lower-class graduates³, social mobility could be had through marriage to a physician, which Mackenzie (1910) and Macbeth (1959) suggest occurred frequently (although a large proportion of nurses remained single).

There is yet another possible reason why young single women entered training schools. Attempts to reform the allegedly deteriorating family were based upon the assumption that only a suitable family environment could create an acceptable citizenry (Hofstadter, 1955). These efforts commonly took the form of modeling institutional forms of care, like the hospital (Editors, 1905), on the family (Sutherland, 1976). The enforcement of a benevolent paternalism (maternalism?) was facilitated since nurses' residences were often part of, if not located in the hospital. Ross (1910) describes the relationship of the nurse to the hospital as that of the child to the parent, one in which the oft authoritarian matron wielded considerable control over the students. Rogers, herself a nursing superintendent, supported the normative basis for this relationship, stating that the "superintendent...must take the motherly interest" in her students (1910:293). Nonetheless, it was precisely this atmosphere that may have reassured parents that their daughters would be living in a suitably supervised family-like environment, since parents were still in a position to influence how their daughters

were employed (see Ball, 1975; Gagan, 1981).

THE TRAINING SCHOOL AND THE LABOUR PROCESS

Entering the Training School

Lawrence (n.d.) and Snively (1985a) note that untrained nurses resisted the emergence of training schools for nurses, because the hospital's reliance upon the labour of students represented a loss in untrained nurses' control over the labour process. Trustees at the Toronto General Hospital dealt with this difficulty by allowing untrained nurses to enter the newly opened training school, but Snively points out that few elected to take advantage of this "opportunity". For many of the women who would later seek employment in private duty nursing, there was little economic incentive to train as nurses, since the public generally did not differentiate between trained and untrained nurses, and tended to rely upon the services of the latter. Moreover, as I will argue later, in spite of the offer to untrained nurses at the Toronto General Hospital, hospital administrators found the younger, inexperienced "generic" candidates preferable for their training schools.

Students entering the training school were required to sign a contractual agreement which stipulated the remuneration they would receive during their training, as well as the period and conditions of their training.

al. (1956) noted that twelve to twenty hour work days were not uncommon, although twelve hours seems to have been the norm (The Mack Training School for Nurses, n.d.; Macbeth, 1959). "Special"⁵ cases, on the other hand, frequently required the nurse to be on duty for twenty-four hours (Campbell, 1956). While some hospitals tried to provide additional time-off, many allowed only one half-day off per week (Street, 1974). Working conditions also remained unsatisfactory (Street, 1974). Nurses' workloads were heavy (Chappell et al., 1956), the living conditions and food for nurses (and patients) were poor (Clarke, 1913; Lawrence, n.d.; Street, 1973), and the risks of contracting disease by the students was high (Coburn, 1974; Gibbon and Mathewson, 1947; Street, 1974). The combined influence of these conditions resulted in high rates of turnover and illness, and even the occasional death (Edy, 1920; Macbeth, 1959; Snively, 1905b).

However, the development of training schools in Ontario had a notable impact on the division of labour among both nurse-administrators and nursing students (Campbell, 1956), and hence also on the decomposition of work. To the ranks of nursing administration were added superintendents of training schools, nursing supervisors and their assistants, and head nurses (Editorial, 1907; Nutting, 1908). The trend towards a breakdown of administrative tasks was most apparent in larger urban

(Campbell, 1956; John H. Stratford Hospital, n.d.; Mackenzie, 1910). While payment of students during the latter stages of training was a common practice among training schools in Ontario, it was more variable during the three month probationary period: many hospitals did (Clarke, 1913; Cosbie, 1975; John H. Stratford Hospital, n.d.; Macbeth, 1959), but others did not (Runnalls, 1974). It seems that the likelihood of finding sufficient students to staff the hospital to some degree influenced the trustees' willingness to offer payment during the probationary period. If few women applied, it became necessary to lure applicants with offers of a stipend during that period (Runnalls, 1974). That such payment was sometimes crucial for training schools, and hence hospitals, is suggested by the case of the Toronto General Hospital. The editor of The Canada Lancet noted in 1877 that the Toronto General Hospital planned to open a training school for nurses, for which applicants would have to pay a fee for training and residence in the hospital (Editor, 1877). By 1879, however, before the school had actually opened, he points out that the proposed course of training had been lengthened to two years, and the hospital was now prepared to pay \$6 per month for the services of its pupils in the first year of their training, (Editor, 1879). Although the editor does not attribute these changes to a difficulty in recruiting applicants, one suspects that

this was indeed the case, particularly since the practice of paying students during the probationary period was widespread.

The contracts can also be seen as hospital administrators' efforts to secure a stable labour force (Craig and Macleod, 1984), which, given nursing labour force fluctuations and the variability of patient numbers within the hospitals, was indeed an important consideration. Attrition was high among nursing students (MacKenzie, 1910). The training school at Toronto General Hospital, for example, enrolled seventeen students in 1881, of whom eight resigned or were dismissed (Gibbon and Mathewson, 1947). At the Lady Stanley Institute in 1903 and 1904, seven of twenty students admitted did not complete the course of training (County of Carleton General Protestant Hospital 1904; 1905), while in 1906, four of sixteen students did not finish (County of Carleton General Protestant Hospital, 1907). As the Special Committee on Nurse Education (1914) found, these rates of attrition were not unusual. Additionally, hospitals faced fluctuating demands for labour owing to the unpredictable nature of hospital use (See Angus, 1973; Cosbie, 1975; MacBeth, 1959; Runnalls, 1974). Epidemics and accidents rapidly increased demands for hospital care and hence nursing labour, while population growth and the progressively expanding demands for institutionalized health care affected nursing labour

demands more slowly. Together these factors necessitated some flexibility in adjusting the nursing labour force.

That flexibility took the form of accepting students at any time during the year when the hospital's work demands required (MacBeth, 1959). Owing to the nature of nurses' training this policy did not prove to be problematic. Since there were no qualifications required of the applicants, and the work was predominantly domestic labour, in which these women were already assumed to be competent, students could "proceed" to the practical content of their educational experience more quickly. In fact, probationers were introduced to the work of nursing rather abruptly (Gibbon and Mathewson, 1947). Ethel Jones recalled that she began nursing practically upon arrival to the training school (Street 1973).

Nursing superintendents did not require any qualifications of the applicants, suggesting that they were not attempting to attract women who were qualified to nurse. What nursing superintendents sought, though, were good health and a middle-class morality. The Mack Training School requested that applicants demonstrate good health and "purity of motive, of good character and Christian conduct" (Greene, 1908:46). Likewise, The Lady Stanley Institute sought healthy candidates who were "of unblemished character", who had to "enclose a clergyman's letter to that effect...", but preference, was given, of

course, to "women of superior...culture" (Macbeth, 1959:41). These moral demands carried over into the workplace (Botting, 1912; Campbell, 1956). Greene (1908), a member of the executive of the Graduate Nurses' Association of Ontario in 1910, admonished students to avoid gossip and present a kind demeanor at all times. McNeill, herself a trained nurse, exhorted nurses to remember that

above all we are to be women of character. Loyal, pure in thought and life, patient, kind and sympathetic, not lacking in forbearance, controlling ourselves in the most trying circumstances, bright, cheerful and entertaining while at the same time serious and firm when necessary (1910:110).

McNeill summarized quite succinctly nursing superintendents middle-class ideal of nurses when she stated that "we are women first and nurses afterward" (1910:110). In effect, nursing superintendents sought to impose upon nurses and nursing a more respectable moral image, one that was consonant with middle-class ideals regarding women's behavior (Editors, 1905; Hodgson, 1908; Hunter, 1905; Lawrence, n.d.).

In order to explain nursing superintendents' concern over the applicant's morality, one must make reference to the broader context of middle-class social reform in Ontario. As argued earlier, some single middle-class women had rejected married domesticity in favour of fulfillment through work. What nursing superintendents wished to create was a "profession" that would be considered respectable

employment for middle-class women, namely women of a superior (ie. middle-class) morality (Vicinus, 1985). Having succeeded in obtaining positions as nursing superintendents on the basis of these very qualities, they proceeded to enforce that morality in the workplace and to screen training school applicants in an effort to eliminate women of inadequate (ie. lower-class) character.

The Work of Nursing

The success of these tactics, though, was limited by the work nurses did. The transition to nurses training had altered the context within which nurses acquired their skills, that is, under the aegis of a training school for nurses. But, the content of nurses' skills, and the conditions and intensity of their work had not changed notably. A commonly referenced early twentieth century nursing textbook includes as nursing duties, assisting a patient with personal hygiene, taking temperatures, applying bandages, poultices and plasters, administering medications, and sterilizing and caring for hospital equipment (Robb, 1906). What Robb fails to point out, perhaps in an attempt to proscribe the boundaries of nursing practice, was that nurses also did the cooking and cleaning (Cosbie, 1975; Chappell et al., 1956), except in the largest hospitals. But even then, auxiliaries were hired to perform these functions only later in the

twentieth century (Campbell, 1956; Macbeth, 1959). In other words, nursing could still be characterized as domestic labour, which was not considered suitable work for middle-class women.

Nurses' duties, though, were not exclusively limited to the hospital's physical boundaries. Hospital administrators retained the prerogative, which in some hospitals was frequently exercised, to send its students to nurse in homes literally anywhere in the province (Macbeth, 1953c; Morley, 1949; Ogden, 1879). The continued inaccessibility of hospital-based care in some regions of Ontario during the late nineteenth century proved to be a benefit to hospital administrators with training schools, since they retained payment for services rendered by students sent out to nurse (Coburn, 1974).⁴ Administrators justified this exploitive practice by stating that it was a means of providing nursing care in areas where no nurses existed (Runnalls, 1974), and that it gave students a valuable learning experience. Although the work setting had changed to the patient's home from the hospital, the work was still predominantly domestic labour.

Like the lack of substantive change in the content of nursing practice, the intensity and conditions of their work had not been notably altered with the emergence of training schools. The hours of work in the hospital continued to be long and time off work brief. Chappell et

al. (1956) noted that twelve to twenty hour work days were not uncommon, although twelve hours seems to have been the norm (The Mack Training School for Nurses, n.d.; Macbeth, 1959). "Special"⁵ cases, on the other hand, frequently required the nurse to be on duty for twenty-four hours (Campbell, 1956). While some hospitals tried to provide additional time-off, many allowed only one half-day off per week (Street, 1974). Working conditions also remained unsatisfactory (Street, 1974). Nurses' workloads were heavy (Chappell et al., 1956), the living conditions and food for nurses (and patients) were poor (Clarke, 1913; Lawrence, n.d.; Street, 1973), and the risks of contracting disease by the students was high (Coburn, 1974; Gibbon and Mathewson, 1947; Street, 1974). The combined influence of these conditions resulted in high rates of turnover and illness, and even the occasional death (Edy, 1920; Macbeth, 1959; Snively, 1905b).

However, the development of training schools in Ontario had a notable impact on the division of labour among both nurse-administrators and nursing students (Campbell, 1956), and hence also on the decomposition of work. To the ranks of nursing administration were added superintendents of training schools, nursing supervisors and their assistants, and head nurses (Editorial, 1907; Nutting, 1908). The trend towards a breakdown of administrative tasks was most apparent in larger urban

hospitals (Lawrence, n.d.), where superintendents of nursing were functionally differentiated from superintendents of the training school. In the smaller rural and urban institutions the nursing superintendents were not only responsible for both of these functions, but were also commonly hospital administrators (Cameron, 1915). Aikens (1908) estimated that in 1908 two-thirds of all hospitals in Canada and the United States were in the charge of nursing superintendents.

Among students an expansion in the division of labour is also apparent, with the resulting status hierarchy determining work assignments (Street, 1973). Probationers, students in the first three months of training, occupied the lowest rung and were delegated "unpleasant" domestic tasks like dusting and scrubbing sinks. Juniors, students between the third and eighth months of training, performed less unpleasant domestic tasks and were also involved with direct patient care. Seniors, a designation commonly applied after eight months of training, were almost wholly concerned with patient care; they took temperatures, administered medications and applied dressings, among other tasks (Campbell, 1956; Gibbon and Mathewson, 1947; MacBeth, 1953a). Again, the division of labour differed somewhat in smaller urban and rural hospitals. Since there were fewer nursing administrators, nursing students were given more responsibilities than their counterparts in the larger

urban centers. Senior students were frequently left in charge of entire wards, or even functioned as head nurses and night supervisors (Hall, 1907). Interestingly, the likely absence of auxiliary workers in smaller hospitals to perform cooking, cleaning and maintenance tasks meant that students in these hospitals also performed such duties.

In addition to the decomposition of nurses' work some skill specialization also occurred, although primarily in the larger urban hospitals (Angus, 1973; Cosbie, 1975; The Hospitals Division of the Department of Health, 1934). Ethel Johns, for example, worked in an operating room, and later also in an X-Ray clinic (Street, 1973). Nonetheless, the extent of specialization was limited as nurses continued to be generalists, a reflection of the rather undifferentiated nature of health care in the hospital.

Rules, which formalized as it were middle-class customs, existed within the hospital to maintain the status hierarchy among students, and between students and nursing superintendents.⁶ McNichol (1971) recalled that senior nurses were never to be spoken to unless concerning patient care, and when they asked a subordinate to do a task, the reply was to be "Yes, Miss...". When a graduate nurse entered the room - most superintendents were by now trained nurses - nurses in training were to rise and stand still as long as she was present. Further, a student's unacceptable moral behavior was a common reason for dismissal from the

training school in one Ottawa hospital (County of Carleton General Protestant Hospital, 1904, 1905, 1906), thus highlighting the concern of middle-class nursing superintendents to maintain proper social convention.

The efforts to maintain status distinctions between nurses, physicians and administrators based upon class and gender, were equally apparent. Middle-class social customs required deference and loyalty from lower-class individuals to those of higher social-classes, but also from females to males. Physicians, and administrators were generally of a higher social-class than most nursing students, and perhaps even some nursing superintendents; but most physicians (Strong-Boag, 1979) and many administrators were also male, while nurses were overwhelmingly female. In addition, physicians maintained that their superior expertise constituted a basis for deference from nurses. One might speculate that class and gender buttressed physician's claims for deference from nurses in the event that their claimed superiority in terms of expertise was not intersubjectively validated by nurses.⁷ Thus, nurses were not to criticize administrators and physicians but to demonstrate unwavering loyalty (The Alumnae Association of the Nicholls Hospital, n.d.). The (male) physician was to remain the nurses' highest authority; after all, a nurse was the "doctors right hand" (Editors, 1883b:326).

Organizing the Training School

Nursing superintendents usually organized the training school for nurses in Ontario. The difficulty of fulfilling that responsibility, and the occasional conflicts with hospital administrators and physicians, produced high rates of turnover among superintendents of training schools (see Angus, 1973; Cosbie, 1975; MacBeth, 1959). Consequently, hospitals were often forced to recruit newly graduated student as nursing superintendents (Runnalls, 1974; Street, 1973).

While nursing superintendents organized and administered the training school, hospital administrators and physicians had a considerable impact upon its form and content. Through their responsibilities in managing the institution, hospital administrators could influence the material taught in the training schools (Henderson, 1914). Administrators at the St. Elizabeth Hospital in Hamilton (Bouchard, 1984) and Toronto General Hospital (Cassidy, 1897) actually determined the curricula of their respective schools of nursing. In effect, they had the power to eliminate lectures or course material they considered "unnecessary" (Nutting 1908), that is, interfered with the student's work.

While hospital administrators could and often did eliminate what they considered to be extraneous course material and lectures, the length of the working day all

but eliminated the need to do so since instruction was given in addition to work (Lawrence, n.d.). Lectures took place after work (MacBeth, 1953b; Nutting, 1908), or during supper hours (St. Joseph's School of Nursing, n.d.). In rural and small urban hospitals, where the student's role was even more crucial to the hospital and fewer physicians existed to give lectures, nurses' education was even further subjugated to their work. A superintendent of nursing points out in The Canadian Nurse that in her small hospital lectures were provided one evening a week, with a further evening of class-work each week (Anonymous, 1905). As I will indicate in the next chapter, the subordination of education to work caused nurse-administrators in the smaller and rural hospitals considerable difficulty in dealing with attempts to reform nursing.

Since work was a major component of nurses' training (Editor, 1903; Macbeth, 1959) the hospital was an important determinant of the quality of their educational experience. Student's ward postings were influenced by the hospital's work requirements, which frequently prevented ward rotation, despite nursing superintendents' belief that work experience on various wards was a necessary part of training (Street, 1973). The training a nurse acquired was also affected by the size and location of the institution and hence the variety of patients it served (Haywood, 1922; cf. Reverby, 1982). Contrary to popular opinion, Dickson

(1923) discounted concerns that the range of disease conditions found in rural hospitals were inadequate to train nurses properly. Instead, she argued that the smaller urban and rural institutions handicapped nurses' training because private paying patients predominated in these hospitals. For Dickson this indicated that students in the smaller urban and rural hospitals could not be supervised as closely, since paying patients stayed in private rooms. This was in contrast to the open public wards of the larger urban settings, which afforded closer supervision and hence better training. Interestingly, since private duty nursing was the main source of nursing employment for graduate nurses, the predominance of public charity patients in the larger urban hospitals meant that students training in these institutions would not be as well prepared for future work as their counterparts in the smaller urban and rural hospitals (Worcester, 1923).⁸

Despite the educational shortcomings, the value of the training process was a foregone conclusion to administrators. In fact, by 1895, many training schools programs had been lengthened to three years, further insuring an available female labor force (Campbell, 1956; Editors, 1898). While some nurse educators believed the increasing sophistication of medical practice necessitated the extra year of training (Richards, 1908), other nursing superintendents and students, complained that no new

material was apparent.

The medical profession also influenced the form that nursing education took. By the 1880's, physicians had become accepted as the rightful proprietors and disseminators of medical knowledge (see Chapter 4). Thus, administrators, physicians and nursing superintendents expected that doctors would lecture to nurses (Belleville General Hospital, n.d.; Campbell, 1956; Chappell et al., 1956; Guelph General Hospital, n.d.; Lawrence, n.d.; Nutting, 1908). This caused some difficulties for nursing students since physicians made no attempt to adjust their terminology to the women they taught (Street, 1973), women who did not possess as extensive an educational background as their physician-instructors. Not only did physicians lecture, but they also examined nursing students (Macbeth, 1959). In effect, by lecturing and examining students, physicians determined what an acceptable level of knowledge for nurses was, thereby influencing the content of nursing knowledge and practice.

However, the response of physicians to nurses' training was ambivalent (Editors, 1897). Many physicians reflected popular social sentiment by opposing higher education for females. This rejection was based upon the "recognition" that men and women were "constitutionally adapted to different work in the world" (Editors, 1892:260). Physicians argued that the competitive

atmosphere of higher education would present an excessive strain on women's abilities to cope (Editors, 1891; Editors, 1892; see Mitchinson, 1984), and thus threaten their capacity to bear and rear children, which was, after all, women's primary role. Even when physicians accepted the training of nurses, it was based upon a recognition of the "constitutional" differences. The work of doctors and nurses was to remain distinct, such that the latter were dependent upon, indeed, subordinate to, the former. Nursing superintendents also supported this differentiation, though. As Reverby (1982) indicates, Nightingale sought to institutionalize this separation of spheres (see Woodham-Smith, 1950).

- Thus, while some physicians believed a longer period of training would better teach nurses their responsibilities (Editor, 1898), the lengthening of nurses' training more commonly exacerbated physicians' perception of nurses as a threat to the medical profession (Richards, 1908). The editors of The Canadian Practitioner (1905:33), perhaps facetiously, but more likely out of real concern, wondered out loud if the graduates of the three year program possessed "more of the 'womanly qualities of tenderness, sympathy and tact,' which are, after all, the important qualities in a good nurse". Many physicians maintained that the extra-year of training represented nurses' attempt to become cheap physicians (Stewart,

1912b). This extra year of "training" should not have presented a threat to physicians, since nursing superintendents had no desire to appropriate physician's responsibilities, except that medical education had itself recently undergone some controversial change.⁹ In light of physician's insecurities over their own education, and in order to assure the domination of nursing by medicine, Dr. Riggs (1916) argued that only physicians should determine what the education of nurses would consist of, since nursing was a subordinate branch of medicine.

Not surprisingly then, physicians hesitated to delegate more responsibility to nurses for fear of undermining their own authority (Stewart, 1912b). Nonetheless, because of their difficulty in coordinating care for growing numbers of patients, physicians were forced to do so, and allowed nurses to perform new tasks such as taking temperatures and pulses. Nursing labour was becoming more skilled (Canadian Nurse, 1916; Ellis, 1909; Russell, 1951; Russell, 1958).

The nature of their work also gave nurses considerable control over particular aspects of patient care. In the operating room, for example, nurses' knowledge about asepsis made physicians respect their ability to maintain a sterile operating environment (Sheperd, 1906). Robb (1906) also points out that nurses were indispensable on the wards because their observations facilitated the

physician's ability to make the correct diagnosis and prescribe the appropriate treatment. These important roles did not go unnoticed by physicians (Editor, 1885), some of whom acknowledged that their success in treating patients was due in large part to nurses' efforts (Editor, 1888). Nonetheless, as Robb (1906:254), a prominent nursing superintendent admonished, "a well trained nurse is never guilty of attempting the diagnosis of a disease." Not only was the nurse not to usurp a physician's prerogative to diagnose and prescribe treatment, as a female she was also not to usurp a male's role (physician).

Nurses Respond

Although for different reasons, training schools in Ontario throughout the late nineteenth and early twentieth century were widely criticized by nursing superintendents and nurses. Over-work was one common complaint. Breay recognized that

A fruitful source of overstrain is the inequitable endeavor of some hospital authorities...to extract work from their nurses to the utmost limit, without giving a due equivalent in training or cash. Women's labour is cheap and plentiful; when some fall out of the ranks others are ready to take their place (1913:154).

Even more bluntly, Paffard, the then treasurer of the Graduate Nurses' Association of Ontario, argued that training schools "were instituted primarily and are being conducted to meet the nursing needs of their respective

hospitals" (1913:298).

Nursing superintendents objected to the existing organization and administration of training schools not so much because it was exploitative, although that was of real concern, but because of the impact of that exploitation on the public image of nursing. The particular nature of the apprenticeship system of training prevented nursing from being seen as a morally acceptable occupation for middle-class women. Nursing superintendents increasingly directed their efforts toward the goal of reforming nursing through the upgrading of nursing education and by achieving licensure.

On the other hand, student nurses were much more pragmatic in their outlook. They sought an end to the long hours, low pay, and poor conditions of their work and residence (see Angus, 1974). But the differing positions of nursing students and their superintendents influenced the means of resistance available to each to achieve change. Nursing superintendents were loathe to make any concerted effort to resolve the problems facing nurses in the workplace. To address the issues of wages and hours of work in a confrontational manner would seemingly contradict their service ideology and any semblance of womanhood. Thus, in their attempts to reform hospital-based nursing through non-confrontational means, nursing superintendents failed to make any significant improvements in the

conditions of their student's work and training.

Although student nurses were limited in the types of resistance they could employ, there was some indication that they did not always passively acquiesce to their superiors. Ethel Johns (Street 1973) noted that a group of students openly opposed the seemingly arbitrary dismissal of fellow students on the grounds of inappropriate behavior. Apparently, the overt resistance surprised hospital administrators, and they reinstated the students. Johns recalls that the gravity of this action only later became apparent to the students when they realized that they could all have been expelled from the training school for insubordination. While direct resistance of this sort undoubtedly occurred in training schools, Macbeth's (1959) account suggests practical jokes and intentionally violating the rules of residence life were more commonly employed to alleviate the stresses they faced. Thus, the precarious position of students within hospital and the enforcement of class and gender appropriate behavior all but required them to accept the conditions imposed upon them.

SUMMARY

Training schools for nurses in Ontario emerged in a context in which institutionalized health care became more acceptable and the medical profession expanded its hegemony

over the practice of medicine. The apprenticeship system of nurses training is significant because it systematically subordinated lower social-class female nurses to higher social-class male physicians and hospital administrators, and female nursing superintendents. Its emergence was based upon hospital's desire to secure a stable, malleable and cheap source of labour. Recruitment, then, was directed at a specific class and gender, namely lower-class women. These objectives, though, came increasingly into conflict with those of nursing superintendents who were dissatisfied with the quality of students the training schools were attracting.

Changes were also apparent at the level of the workplace. The work of nursing became more skilled, as some medical tasks were being delegated to nurses. On the other hand, nursing was still largely domestic labour, although in some hospitals other non-nurse employees were assigned these functions. Thus, the division of labour also expanded, not only within the hospital at large, but also within nursing itself. The range of upper level nursing positions expanded to include head nurses, night supervisors, and superintendents of training schools. These changes facilitated increased worker control and coordination. At the same time, students were hierarchically differentiated, as their status also determined work responsibilities.

Control over the nursing labour process also became more complex with the emergence of the training school. While nurses retained control over the method in which specific tasks were executed, the demands placed upon nurses by hospital administrators and physicians shaped the content of nursing work. Hospital administrators limited the extent of actual education during the training period by requiring of its students a long day's labour, while physicians delimited the content of nursing practice by virtue of their monopoly on medical practice, and their role in lecturing and examining nursing students.

Nonetheless, direct worker control was still exercised through personal relations, and expectations of class and gender-specific behavior. The influence of middle-class nursing superintendents became increasingly apparent in this regard as they attempted to impress upon nurses their own middle-class values.

Nursing superintendents' attempts to improve the status of nursing, though, were constrained by their middle-class ideologies, which also forced them to ignore more direct strategies to improve the work and education of nurses. As will become apparent, the conflicting needs of nurses and the professional aspirations of their leaders, in addition to other factors, shaped the development of institutional care, and influenced the direction of nursing development throughout the early twentieth century. Nursing

leaders finally realized an important goal in 1922 with the passage of the Nurses Registration Act. The struggle to achieve registration, and its impact upon the labour process, will be the focus of the next chapter.

CHAPTER 7:
NURSING REFORM:
EDUCATION AND REGISTRATION

The early twentieth century brought a number of important changes to institutionalized health care in Ontario. One notable development was an increase in the number of training schools for nurses.¹ Additionally, nursing leaders, a small group of self-conscious nursing superintendents who had organized, eventually achieved one objective in their attempt to reform nursing, that is, nursing registration. This chapter will examine how the relationships between physicians, hospital administrators, and nursing superintendents and nurses affected the outcome of nursing reform, and hence the labour process.

THE HOSPITAL'S CHANGING FACE

Near the turn of the century hospital administrators in Ontario demonstrated a growing attention to financial management. Declining charitable and voluntary contributions, a lower per diem rate of payment from the province (Editor, 1907), and a reluctance by some municipalities to pay for the care of their patients (Cosbie, 1975), heightened concern among administrators (Ontario Hospital Association, 1902), particularly in light of an expanding demand for hospital-based care. As noted previously, their response to these conditions took three basic forms.

Hospital administrators became more aware of the potential benefits of acting collectively in order to promote the hospital's needs, especially financial. Thus, in 1902 administrators met to discuss, and form a provincial hospital association, the Ontario Hospital Association (Ontario Hospital Association, 1902). The stated objectives of the association were to procure greater provincial government aid for non-paying patients, to increase county and municipality aid, and to promote the hospital's interests. Since nursing superintendents were still frequently hospital administrators, they played an important role in realizing the organization's interests (Anonymous, 1910).

The emergence of a more self-interested administrative corps was associated with a recognition of the importance of more rational administrative techniques (Smith, 1907). Financial difficulties continued to plague hospitals, which in turn affected the banks' willingness to extend lines of credit (Cosbie, 1975). Since government funding was to some extent contingent upon the inspector's evaluation of hospitals' administrative practices (Splane, 1965), administrators had further incentive to rationalize hospital management. Rationalization took the forms of hospital standardization (MacEachern, 1922), bureaucratization and, in some hospitals, cultivating an interest in Taylorism as a means of improving hospital

efficiency (Stewart, 1912b). Thus, shortcomings that had been recognized for some time, such as an absence of patient records (Wright and Cameron, 1881) for example, were finally addressed in efforts to improve hospital management and the institution's financial outlook.

The continuing financial difficulties and increasing complexity of hospital management also forced boards of directors in many Ontario hospitals to reevaluate their upper-level administrative staff. A consultant hired by the Kingston General Hospital to assess its administrative requirements, urged the hospital to separate administrative from medical functions, noting that medical expertise was not a requisite for sound financial management. This change was opposed by physicians who recognized that their influence over hospital management would decline. Nonetheless, the hospital board hired the hospital's first non-physician, non-nurse hospital superintendent in 1923 (Angus, 1973). Thus, "professional" administrators began to take a greater role in hospital operations (Guest, 1972), although primarily in large urban institutions; nursing superintendents continued to administer smaller and rural hospitals (Cameron, 1915). However, with the emergence of professional administrators, and the increasing rationality of hospital management, the interests of administrators in running the hospital as a business increasingly conflicted with the goals of physicians to widen their professional

sphere within the hospital (Decker, 1923) as well as the interests of nursing superintendents in reforming and professionalizing nursing.

In spite of complaints over "hospital abuse"² more paying upper and middle-class patients entered the hospital. Dickson (1923), notes, though, that this phenomenon affected urban and rural hospitals differently. She found that rural hospitals serviced a significantly higher proportion of private (paying) patients, while urban hospitals, even though they attempted to accommodate more paying patients, had a higher proportion of charitable (non-paying) patients. This distribution of paying and non-paying clientele is supported by the frequent complaints from urban hospitals that surrounding municipalities failed to adequately finance the care of their sick-poor (Ontario Hospital Association, 1902). As I have already argued, the relatively higher proportion of private patients in rural hospitals and of charity patients in urban hospitals had an important consequence for the training rural and urban hospitals provided their nursing students (Dickson, 1923). But these differences also influenced the responses of nursing superintendents in regard to efforts to introduce registration legislation for nurses.

The increasing numbers of middle-class paying patients in hospitals, and their disdain for lower-class

nurses, made a cheap, well disciplined student labour force more valuable to administrators. Administrators knew that the greater disciplinary control which students' labour afforded could decrease the likelihood that an undisciplined nursing labour force would make hospital care unattractive for paying patients. Additionally, administrators recognized that the higher labour costs of graduate nurses compared unfavourably with the cheaper labour of nursing students. Relying on students then, also presented a distinct economic advantage to the hospital:

A considerable revenue will probably be derived from services rendered...by nurses who have not completed their time (in training), but who will be competent to take charge of a sick room, the charge made by the hospital for such services being in excess of the cost (to the hospital) of the nurses (MacDermot, 1940:28).

Thus, administrators based their reorganization of hospital care upon an expansion of private and semi-private wards ("Practitioner", 1908), and the ability of nursing students to provide satisfactory care for the hospital's middle-class clientele.

Apparently, these changes also made the technical abilities of nurses in patient care more important, particularly in light of the expanding scientific content of medical practice. Thus, while hospital administrators found the apprenticeship model adequate for training nurses, some physicians began to advocate the employment of graduate nurses on the grounds that the use of students in

a role requiring the skills of a trained nurse was inadequate (Halpenny, 1919). Students were simply not seen as sufficiently skilled to meet the demands of scientific medicine. Although nursing superintendents opposed the apprenticeship model as well, it was on fundamentally different grounds.

THE STRUGGLE FOR REFORM

Organizing Nursing

Nursing superintendents became more vocal about what they perceived to be shortcomings in the apprenticeship system of nursing education. Little had changed in training schools since they first developed in Ontario during the late-nineteenth century. Hours remained long, workloads heavy, living conditions within hospitals poor, and perhaps most importantly for many nursing superintendents, education remained secondary to work for student nurses. Clarke (1913) notes that some students graduated from their respective training programs without having attended any lectures. The exploitive nature of the existing training system was particularly objectionable in view of the aspirations by nursing superintendents to improve the image of nursing. Many of them believed that the apprenticeship system restricted professional development (Paffard, 1913; Stewart, 1912b), an expression which referred to their goal to create of nursing an acceptable

"middle-class" occupation. In support of this contention, superintendents pointed to the lack of respect nursing received from the medical profession (Stewart, 1912b), and the public's continuing use of untrained instead of trained nurses. In other words, the complaint by nursing superintendents that few were able to differentiate between trained and untrained nurses (Eastwood, 1907; Street, 1973), can be interpreted as a sign that nurses and nursing were still not well respected.

Nursing superintendents believed that to create an image of middle-class respectability for nursing, two major changes would have to be achieved. Nursing would have to obtain the power to control the licensing of its practitioners. Additionally, the apprenticeship system of education would have to be replaced by training in the public educational system, namely in universities and technical colleges. But to achieve these goals, nurses needed to organize (Fogarty, 1909).

Alumnae associations were the first product of efforts to organize. In Ontario the first alumnae associations formed in the late nineteenth century (Gibbon and Mathewson, 1947; Registered Nurses' Association of Ontario, 1963). Nursing superintendents were quick to recognize that the alumnae associations' parochial nature (Fenwick, 1908; Groves, 1907; MacBeth, 1953c)³ hindered collective action. While international and national nursing organizations had

begun developing since the end of the nineteenth century,⁴ it was only in 1904 that the Graduate Nurses' Association of Ontario (GNAO) formed by organizing alumnae associations in the province (CNA, 1968; Riddell, 1970).

The constituents of the GNAO were elite; their objectives equally so. Like its national counterparts, the GNAO was constituted by a small group of influential nursing superintendents from hospitals and training schools in Ontario, many of whom were also involved in other nursing organizations.⁵ These superintendents foresaw the possibility of attaining respectability for nursing by improving the standards of nursing education; and controlling entry into nursing practice through registration (Paffard, 1913).

That some of the women in the GNAO were active in more than one organization shows that this relatively small group of nursing superintendents had achieved a state of self-awareness regarding their potential influence within nursing. Through their positions in these organizations and their administrative positions in Ontario hospitals, these nursing superintendents became the self-appointed leaders of nursing and its project of reform. Commentators lamented graduate nurses' failure to join the GNAO (An Ex-Private Duty Nurse, 1923; Bowerman, 1906; B.L., 1908), a tendency that suggests graduates recognized the power of nursing leaders in the GNAO, and their own weakness. The lack of

support from nurses, however, limited the GNAO's potential impact, although its efforts were also hindered because women still did not have the vote...the "person's" case was not heard until 1928 (Bassett, 1975). Nonetheless, the organization was important, not because it was instrumental in achieving the Nurses Registration Act of 1922, but also because of the influence its middle-class constituents had on the labour process in reforming nursing.

Legislative Reform

Soon after forming the GNAO nursing leaders drafted a Bill for incorporation and registration, and presented it to the Ontario Legislature in 1906. Observers suggest there was little resistance voiced against the principle of the measure (MacNab, 1970; Paffard, 1913), but only against its provisions. The debate over the Bill suggests, however, that there was considerable opposition to its intent, namely to standardize nursing education, recognize the GNAO as the sole registering body for Ontario nurses, provide it with the power to recognize graduates of accredited training programs as Graduate Registered Nurses, and limit the practice of nursing in hospitals receiving government funds to registered practitioners (Knisley, 1926; MacNab, 1970).

Opposition to nursing leaders' proposal for self-governance came from physicians and hospital administrators

who maintained that such a policy would effectively negate what they maintained to be their legitimate interest in determining nursing policy (Knisley, 1926; MacNab, 1970).⁶ Hospital administrators also felt that higher educational standards, and limiting nursing practice exclusively to registered graduate nurses would be undesirable (MacNab, 1970). Administrators saw that these changes would require them to improve the conditions of nurses' training, and to hire graduate nurses, concessions they were unwilling to allow because of the financial consequences, and a potential loss of some control over their nursing labour force. In view of this opposition, the Special Committee evaluating the Bill rejected it as "too strict" (MacNab, 1970:117). The suggested changes to the Bill were unsatisfactory to nursing leaders, and it was withdrawn (Mathieson, 1906; Paffard, 1913).

Widespread support for the recommended changes did not exist among nursing superintendents either (Hall, 1907). The proposal to standardize education raised the question of whether trained nurses from small hospitals should be eligible for registration (Bowman, 1912). Many superintendents from the larger training schools argued that the smaller hospitals did not provide their students with a sufficiently broad training, and would consequently limit their graduates' ability to function in the larger hospitals. As indicated earlier, however, Dickson (1923)

later discounted this notion by pointing out that the breadth of experience was satisfactory in the small urban and rural hospitals.⁷ The main reason for nursing leaders' concern regarding the smaller training schools can be explained with reference to their lower entrance standards, which then affected the "quality" of students these training schools accepted (Rogers, 1910), and hence also the image of nursing in these institutions. Nursing leaders had been dissatisfied for some time with the "quality" of applicants many training schools attracted (Stewart, 1912a), students whom Nutting (1908:585) characterized as "badly brought up, irresponsible [and] unrefined". Since efforts to impose middle-class standards upon their lower-class students had been largely unsuccessful, nursing leaders felt the only way to improve the image of nursing was to attract a "better class of applicants". (Stewart, 1912a:125), namely those with middle-class qualities. This objective could be achieved by increasing minimum educational requirements (Rogers 1910), hiring graduate nurses, requiring the affiliation of smaller training schools with larger and better equipped training schools (Bowman, 1912), or by moving the educational program out of the hospital and into the universities and vocational schools (McLeod, 1919; Special Committee on Nurse Education, 1914; Stewart, 1912a).

These strategies and their potential consequences

were clearly not satisfactory to many superintendents of training schools in the smaller Ontario hospitals (Bowerman, 1907b). These women, many of whom were also hospital administrators, pointed out that raising minimum educational standards or shifting the location of the training schools would decrease or eliminate the number of student nurses that could be attracted to staff the wards in the small hospitals. They also resisted the employment of graduate nurses because of their intermittent labour force participation. In contrast to graduate nurses, who could leave the hospital to seek work elsewhere, or might leave nursing altogether for marriage,⁸ nursing students provided a captive labour pool (MacKenzie, 1910). It is probably also reasonable to expect that nursing superintendents in the small hospitals also resisted the standardization of nursing education because it would remove some of their discretionary power and control over the training program (see Reverby, 1982).

By 1910 the GNAO had drafted a second Bill, but it was never presented to the Ontario Legislature (MacNab, 1910). Further, although a 1912 amendment to The Hospitals and Charitable Institutions Act provided an opportunity for nurses who had graduated from training schools in hospitals receiving aid under the Act to register, nursing leaders rejected the changes because they did not limit the practice of nursing to qualified registrants. Nursing

leaders argued that permissive legislation could not effect a change in the public's image of nursing if untrained nurses would still be allowed to practice.

Two large-scale studies of nurses' training followed shortly after this amendment. Although their objective differed, the 1914 evaluation of training schools commissioned by the Special Committee on Nurse Education of the GNAO, and the Royal Commission on education and medical practice in Ontario (Hodgins, 1918; Knisley, 1926; Special Committee on Nurse Education, 1914) overlapped considerably in their findings. However, they differed significantly in their recommendations. Not surprisingly, the report of the Special Committee on Nurse Education echoed the objectives of its parent organization and suggested sweeping changes to the organization of training schools and the educational and work experiences of its students. On the other hand, although acknowledging the legitimacy of registration as an attempt to deal with the exploitation of students' labour, Hodgins (1918) rejected nursing leaders' proposal for a restrictive registration policy, arguing that a monopoly on nursing practice was not in the public's best interests.⁹

Meanwhile, the Ontario Commissioner of Labour had determined that since nursing was not a profession it was eligible to join organized labor in supporting a reduced work day (Crosby, 1915b). Such organization was opposed by

physicians and hospital administrators who used the example of a similar situation in California (see Melosh, 1982) to argue that achieving goals through confrontational means would prevent nursing from becoming a profession. Like their counterparts in California, however, nursing leaders resisted organizing as a union, stating that it was not compatible with professional behavior (Crosby, 1915b; Flaw, 1919). In fact, nursing leaders opposed any attempts to fix the hours of work and rates of pay on the basis that such action would contradict an ideology of service, and hence also professionalism. If working hours were to be shortened and better work conditions be achieved, it would have to be through professional, non-confrontational means.

World War I intervened, and pre-empted the realization of nursing reform in Ontario. Large numbers of medical and nursing staff left for the war fronts, which severely affected hospital functions (Gibbon and Mathewson, 1947; MacBeth, 1953b; MacDermot, 1940). Some hospitals reduced or even suspended services, some training schools interrupted training programs, and many alumnae groups postponed their activities (Ink, 1919; MacPhail, 1914; St. Joseph's General Hospital, 1958/1959). If the American situation is any indication of what occurred in Ontario, the shortage of staff and supplies resulting from the war effort worsened work conditions (see Melosh, 1982; Reverby, 1982). Fewer nurses meant that students were responsible

for more patients. This work overload was further exacerbated by the increasing public use of hospital's facilities as a result of a depressed war economy. The war effort and its attendant austerity measures were also used by administrators as rationale for intensifying nursing work and lowering rates of pay.

The impact of the war also affected private duty nurses greatly. In a depressed economy fewer families could afford to hire a private duty nurse (Gibbon and Mathewson, 1947). This forced many private duty nurses to significantly lower the rates they charged in order to become more competitive with untrained nurses, while others literally begged hospitals to hire them (Reverby, 1982).

The efforts of nursing leaders to effect reform were also hampered by the war effort (King, 1970). The federal government had placed restrictions on the activities of labour organizations (Rhamkhalwansingh, 1974), and thus precluded nursing leaders from bargaining for any concessions from hospital administrators.¹⁰ Moreover, Pringle (1915) noted that the GNAO faced greater difficulty in getting nurses involved with the organization because of the war effort.

The post-war period presented further difficulties. The return of thousands of nurses meant that work had to be found for them. In the face of a declining demand for private duty nurses, nursing leaders encouraged hospitals

to hire more graduate nurses (CNA, 1968; Gibbon and Mathewson, 1947), a possibility that was facilitated by hospitals' expansion to meet a greater post-war demand for services. These trends were exacerbated by the depression of the 1920's, which forced many more patients into the hospitals, and further decreased the demands for private duty nurses (CNA, 1968). At the same time, training schools for nurses experienced a declining enrolment (Bouchard, 1984; Duncanson, 1970), particularly in the smaller urban and rural hospitals (MacPhail, 1918).

University Education and the 1922 Nursing Act

Thus, attempts at educational reform and the pursuit of registration resumed in the context of a growth in hospital-based care, a slow expansion in the employment of graduate nurses in hospitals, a declining demand for private duty nurses, and a decrease in the number of nursing students.

Since the turn of the century nursing leaders had insisted on the necessity of university-based education for nurses. Their efforts to develop Canadian university programs were hindered by a number of factors. University education was still not widely accepted for women in Ontario (Hampton-Robb, 1985), hence encouraging those interested in pursuing higher nursing education to go to the United States (Street, 1974). The medical profession

opposed a university-based nursing program because it was perceived as a threat to their position within the health care system. Hospital administrators also objected to this potential shift since it represented a loss of cheap, controllable labour, which would require them to hire more costly and independent graduate nurses. University administrators were also reluctant to implement such a change because of limited financial resources (King, 1970).

The first Canadian university-based nursing program only began in 1920 at the University of British Columbia. Macdonald (1969) argues that even then this development was merely symbolic of an attempt to garner status, since the actual content of nurses' education had not changed notably. Moreover, hospital schools retained control over the clinical portion of the curriculum since the university claimed it lacked the qualified instructors and funding required to develop a clinical program (Street 1974).

Although not without difficulty, the Nurses Registration Act was passed in 1922 (Riddell, 1970). The Act was to regulate the approval of training schools, and the registration of graduates (Knisley, 1926; MacNab, 1970). It required that an approved training school have a course length of two years with a specified curriculum. If the training school lacked adequate facilities to train its students, it was to affiliate with better equipped schools. Registration was to be conferred only after the candidate

passed a standard examination. The Act also required that an Inspector of Training Schools be appointed, who would inspect and keep a record of approved training schools. The regulations of the Act met with continuing resistance on the part of hospital administrators, and their implementation was therefore delayed until after a study of training schools had been completed in 1923 (Dickson, 1923).

The Graduate Nurses' Association of Ontario considered passage of the Act somewhat of a compromise since nurses had not been granted self-governance (Coburn, 1974). Furthermore, curricula guidelines were not stringent, and wide variations existed between hospitals in terms of their educational requirements, the minimum number of hospital beds required for a hospital to qualify for a training school, and the number of instructors required for approval of a training school. While nursing leaders had finally realized an important goal, the achievement was hollow. Although the registration act provided nursing leaders with some control over entry into nursing, the provincial Department of Health exercised the most control over registration. Moreover, the hospital-based apprenticeship system of education remained entrenched, shattering nursing leaders' hope that the legislation would effect a change in the image of nursing.

In fact, Dickson's study revealed that little change

had occurred in the conditions of nursing education and work since the turn of the century (Dickson, 1923). Nursing could not yet be considered an acceptable occupation for middle-class women.

THE CHANGING LABOUR PROCESS

As noted, the apprenticeship system of training continued to shape the nursing work. Also, control over the labour process changed as a result of the evolving roles of hospital-based care, the medical profession, "professional" administrators and nursing leaders in a burgeoning health care system.

Entering the Training School

By the beginning of the twentieth century nurses' training schools in Ontario experienced a declining enrolment (MacKenzie, 1906; Nutting, 1908), although it was more severe in the smaller urban and rural hospitals (MacPhail, 1914). A survey of Canadian training schools by the Canadian Red Cross Society (1921) near the end of World War I found that 40 per cent claimed a shortage of student nurses, a shortage which was attributed to military mobilization and the increasing availability of other more attractive occupations. The latter factor was particularly instrumental in perpetuating the shortage of nurses during the post-war period. Cameron (1922) compares the pay of

private duty nurses with that of teachers and asks rhetorically if women should continue to seek employment in nursing when its wages remained lower than those in other occupations. In spite of an increase in the number of women seeking employment, the availability of better paying work in urban centers, coupled with the difficult training conditions and a decreasing demand for private duty nurses (Ewing, 1915) to contribute to a decline in the number of nursing students (Carter, 1921).

Additionally, some training schools raised admission standards (Winslow, 1920), or required its students to pay for their education (Nutting, 1908), which further narrowed the potential pool of students. For example, in 1921 the Hamilton General Hospital School of Nursing required its applicants to possess two years of high school education instead of the single year previously stipulated (Campbell, 1956). Other schools no longer paid a stipend or provided free room and board; instead they eliminated the residency requirement and imposed a fee for training (Editor, 1905). While on the surface these policies appear inconsistent with the declining number of nursing students and the resulting difficulties in staffing hospitals, they were consonant with nursing leader's efforts to attract a "better class" of applicants. Nursing leaders believed that by increasing educational pre-requisites and students to pay for their training, only a "higher type of women"

(Editor, 1905:366) would be able to enter training schools. That is, only daughters from wealthy families could then qualify for, and afford to enter training schools, thereby excluding lower-class applicants, and hence resolving the image problem of nursing.

The difficulties in drawing sufficient numbers of students to staff the hospital wards in all but the largest and most prestigious urban hospitals suggests that these policies could not be widely applied. Dickson's (1923) study indicates as much. She noted that in most training schools low educational requirements existed, and stipends continued to be paid, which suggested that very few institutions chose to eliminate these practices owing to the difficulties of attracting students. Further, her report implies that the "better class" of women was not apparent in training schools, since most continued to come from rural areas and the urban lower-class (see MacKenzie, 1906; Nutting, 1908). In other words, while nursing leaders attempted to reform nursing into a respectable occupation for middle-class women, the predominance of rural and working-class women in the training schools suggests that the (middle-class) public had not yet embraced the nursing leaders' conception of nursing.

The Work of Nursing

The fact that the middle-class did not yet see nursing as respectable work for their daughters indicates that the conditions of nursing labour had not changed greatly in Ontario since the turn of the century. This was the case.

Nurses' work still consisted mostly of domestic tasks, namely food preparation, bedmaking, cleaning, and assisting patients with personal hygiene, although it also included applying dressings, poultices and bandages, and administering medications (Campbell, 1956; Russell, 1951). Nonetheless, their technical skills expanded as medical practice became more sophisticated and physicians delegated to nurses previously held medical responsibilities, such as taking pulses and temperatures. These changes were more apparent in specialized care areas, such as the operating room, and the X-Ray and outpatient clinics (see Angus, 1973; Cosbie, 1975; Street, 1973), which developed largely in the major urban centers. The slow and uneven nature of these changes left nursing a general and relatively non-technical occupation.

Nursing superintendents in some training schools attempted to deal with the "drudgery" of nursing labour by delegating some tasks to other auxiliary workers (Carter, 1921). Campbell (1956) notes that the Hamilton General Hospital School of Nursing began to relieve its

probationers of tasks that had no educational value, although no indication is given of what was not considered to be of educational value. This practice was probably not widespread, though. Macbeth (1959) points out that the County of Carleton General Protestant Hospital relied on its students to clean the wards, wash kitchen utensils, and even perform general maintenance duties. In sum, most hospitals in Ontario depended almost exclusively upon the labour of its students, a conclusion that Dickson's 1923 study bears out. She found that of ninety training schools visited, ten had hired only one graduate nurse, eleven had only two, and sixty-nine had three or more. Further, in most hospitals graduate nurses were employed in administrative and not ward nursing positions.

Neither had the conditions of work changed significantly. Long working hours drew the ire of nurses, nursing leaders (Crosby, 1916), and even some physicians (Haywood, 1922). Twelve hour shifts remained usual, as did the more extended duty for private cases. Edy (1920) and other nursing leaders argued that long workdays not only increased the numbers of errors made by nurses, but also led to high rates of illness and the loss of competent nursing staff. In Ontario, nursing leaders pursued an eight hour day throughout the 1920's (see Cameron, 1922; Carter, 1921; Haywood, 1922; Winslow, 1920). Since they continued to reject the use of confrontational means to achieve this

goal, nursing leaders attempted to convince administrators of the need to institute a shortened work day. Administrators rejected their arguments on the basis that such a change would raise labour costs (Haywood, 1922; Lawrence, n.d.). Extra students would have to be "hired", which would not only increase the sum of stipends paid, but also the expenses of accommodating more students in nursing residences. Administrators maintained that the hospital could not bear these costs. Thus, shifts remained twelve hours in length for Ontario hospital nurses until the 1930's (Angus, 1973; Coburn, 1974).

The structure and rigidity of the division of labour in nursing also remained relatively unchanged, although it expanded in many hospitals. An individual's position within the nursing hierarchy still determined her status relative to other nursing staff, and also her work responsibilities (Street, 1973). Probationers continued to occupy the lowest rungs of the status hierarchy and performed the most menial of "nursing" tasks. Senior and graduate nurses, on the other hand, were frequently left in charge of the wards and acted as night supervisors (Winslow, 1920).

The extent of direct supervision, however, varied between urban and rural hospitals in Ontario. As Dickson (1923) observed, public wards predominated in urban hospitals, while private wards comprised a large proportion of all wards in the smaller rural and urban hospitals.

Since patients in private wards were isolated in a room, nursing students were less amenable to close supervision. Students in urban hospitals, where public wards were more common, could be supervised more directly since patients were clustered together. Additionally, because fewer nurse administrators staffed the smaller institutions, students were delegated a broader range of duties in comparison to their counterparts in the larger urban hospitals. Together, the wider range of responsibilities and less direct supervision suggest that students in the small urban and rural settings had considerably more latitude in fulfilling their duties. In other words, they retained more control over the labour process.

The rationalization of administrative practices within the hospital during the early twentieth century also affected nursing. As coordination and control of the nursing labour force began to separate, the two functions were delegated to different groups of nurse managers, although the expansion in the administrative division of labour was less pronounced in the smaller urban and rural hospitals. Upper-level nursing staff were further separated from ward nursing by the growing burden of administrative responsibilities, and direct control over the nurses became the responsibility of head nurses (Angus, 1973; Cosbie, 1975). Nonetheless, while bureaucratization became more apparent within the hospital, discipline and control of the

labour force continued to be based upon personal relations (Macbeth, 1953b), and conceptions of class and gender-appropriate behavior. Macbeth (1959) relates that nurses responded primarily to the personal character of their nursing superiors and not necessarily the position itself.

In spite of administrator's increasing authority in hospital management, physicians retained and expanded control over the direction of patient care (Angus, 1973; Cosbie, 1975). Nurses, however, recognized and acceded to physician's authority in this regard. This deference, which was occasionally even codified (Runnall, 1974), was based not only upon physicians' scientific expertise (Blythe, 1919), but also upon their class and gender. And, as agents of middle-class social convention, nursing superintendents sought to ensure that their charges fulfilled those expectations.

Thus, nurses' training was not merely a preparation for patient care. Worcester (1923) and Greenham (1923) maintained that training taught nurses their proper relationship to doctors and other superiors, as well as to their classmates, juniors and patients. In other words, nurses' training properly socialized the incumbents of a particular social role and status. The image of the training school as a "finishing school" for girls of less well-to-do families, which would prepare them for the moral intricacies of social life, had not been superseded by the

view of training as a process of more-or-less scientific training. Nursing was still considered subordinated women's work.

Nursing leaders continued to express dissatisfaction with nursing's subordinate status, as they sought to reform nursing. On the other hand, periodically nurses responded to administrative control in a more militant manner. Angus (1973) notes that in 1920 three nurses had been suspended at the Kingston General Hospital, but were quickly reinstated when administrators recognized that nurses' threat to go on strike if their demands were not met was not an idle one. Nurses' attempts to effect changes at the level of the workplace, however, were constrained by the efforts of nursing leaders to achieve change through less direct and non-confrontational means. Graduate nurses opposed their own leaders' efforts, which were based upon a refusal to accommodate demands to unionize, by not becoming active in nursing associations.

Nursing Education

Some changes occurred in the training school's educational process. The most important of these were an increase in the educational content on nurses' training and an expansion of the role of nurse-educators within the schools.

Nursing superintendents in Ontario had for some time

been concerned over the quality of nurses' education, particularly regarding the unsystematic nature of physician's lectures in the training school. Macbeth (1959) noted that physicians lectured when they were able, and did not coordinate the content of their lectures with other physician-lecturers. As a result, material was frequently over-lapping, when it was provided at all. Macbeth argues that this situation "forced" an increasing reliance on nurse-educators. Dickson (1923), on the other hand, explains the growing role of nurse-educators as an effort to conserve the physicians' time and energies. In fact, both of these accounts portray too passive a picture of nursing leader's efforts.

Under the rubric of professionalization, nursing leaders actively attempted to delineate a body of knowledge that could be considered distinct to nursing. This knowledge was to include the theoretical, practical and ethical aspects of nursing practice (Macbeth, 1959). Some nursing superintendents also expanded the curriculum and thereby increased the time students spent in lectures (Cosbie, 1975), particularly as probationers. In some hospitals the probationary period of training was extended, while in others work responsibilities during the probationary period were replaced with theoretical education (Stretton, 1915; Stanley, 1908).

Nonetheless, physicians retained considerable control

over nurses' education. For example, the curriculum of the Lady Stanley Institute between 1909 and 1924 included 302 hours of lectures, of which 68 hours (22.5 per cent) were given by physician's (many training schools were more dependent upon physician's lectures than the Lady Stanley Institute. See Angus, 1973; Cosbie, 1975). The theoretical, practical and ethical aspects of nursing practice comprised 40 per cent of the total lecture hours (50 per cent of those given by nurse-instructors), while the remainder of the lectures (60 per cent) dealt with medical topic areas, namely anatomy and physiology, hygiene, materia medica, and surgery (Macbeth 1959). In other words, nurse-educators attempted to delineate a body of knowledge for nursing that was based upon and complemented the medical model of health care. Thus, the medical profession continued to play an instrumental role in nurses' training (Lawrence, n.d.), through both providing lectures and by shaping the content of nursing knowledge.

Dickson's (1923) study of training schools was quite critical of the entire educational process. She notes that while the role of nurse-educators expanded, and while they demonstrated skill in teaching practical techniques, "in their presentation of theory there was almost always evidence of a lack of knowledge of teaching principles - consequently both time and energy were vitiated" (Dickson, 1923:9). Moreover, Dickson criticized the schedule of

lectures for being unsystematic, and states that the supervision of students in smaller and rural hospitals was frequently inadequate. While she observed that a few training schools had affiliated with better equipped schools in order to improve the students' educational experience (see MacBeth, 1959), Dickson blames hospital administrators for continuing to subvert educational reform by requiring students to work, and by providing inadequate resources to improve the facilities. Thus, despite the efforts of nursing leaders and nursing superintendents, Dickson concludes that little had changed since training schools first emerged.

SUMMARY

The growth in the proportion of middle-class patients in the hospitals following the turn of the century coincided with an expansion in institutionalized health care delivery in Ontario. These changes had important effects on the division of labour within the hospital and the labour process of nursing. "Professional" administrators emerged and applied more rational techniques in hospital management. While this improved the hospitals' financial outlook somewhat, administrators' more rational economic objectives also brought them more into conflict with those of physicians and nursing leaders.

Nursing leaders, a small group of self-conscious

nursing superintendents, showed a more concerted effort to reform nursing into an acceptable occupation for middle-class women. The GNAO directed its energies at two goals: improving education and obtaining registration.

Nonetheless, the government Bills and educational reforms it proposed were widely resisted, not only by physicians and hospital administrators, but by other nursing superintendents and even nurses themselves. In a context in which other more attractive occupations existed, nursing superintendents' attempts to attract a "better class" of students failed. Instead, the number of nursing students declined. Nursing leaders' efforts culminated in the Nurses' Registration Act of 1922, an Act which they found unsatisfactory.

Little change was manifest at the level of the workplace either. Although the educational curriculum expanded and nurse-educators took a more significant role in the educational process, nurses training was still based upon the medical model and there was little effort to challenge the pivotal role physicians played in nurses' education. Further, administrators retained considerable control over the training school in spite of evidence of change in nurses' education.

The work and conditions of nursing had also not changed substantially. The hours of work remained long and work conditions poor. Nursing was still constituted

largely of domestic tasks, although some hospitals made an effort to eliminate some of the drudgeries of hospital work by passing them on to auxiliary workers. Advances in medical practice were also reflected in nursing practice as physicians delegated tasks to nurses that they had previously performed. The division of labour expanded further, creating a collective, versus individual, worker. Nonetheless, while administrative rationality became more apparent, control of the nursing labour force was still based upon personal authority and expectations of class and gender appropriate behavior. Nursing was still lower-class women's work.

PART V

CONCLUSION

This analysis of the history of nursing and its labour processes in Ontario indicates three broad phases of development, which approximated broader social and economic changes (cf Reverby, 1982). These include the emergence of institutional care prior to 1874, a period of development between 1874 and 1900 in which nurses training schools were emerging and expanding, and the period from 1900 to 1922 in which efforts to reform nursing increased, culminating in the Nurses Registration Act.

As I have argued, prior to the 1870's institutional care was not widely accepted, and hence, few nurses were employed in hospitals. In keeping with the individual social Darwinist ideology of the period, poverty and illness were considered responsibilities of the individual, family and community. Physicians were not yet instrumental in providing health care and had little influence over nursing practice. Further, although hospitals were ultimately the responsibility of the trustees, the responsibility for the day-to-day operations of the institution were most frequently delegated to nursing matrons.

Central to these institutions was the work of nurses, which was comprised largely of domestic tasks. Women's employment in them was a function of the task composition of hospital work, since domestic labour was considered to

be women's work. The poor social perception of nursing is reflected in the pervasive Dickensian image of the work and its incumbents. The conditions nurses faced in hospitals were poor, the hours of work long, and the nurse-patient ratios low. In fact, it was primarily on the basis of their ability to withstand these conditions that nurses were employed. Nonetheless, nurses wielded considerable control over the labour process. Much of their work went unsupervised; although the hospital "regulated" their access to clientele (patients). Matrons controlled their nursing labour force through personal relations based upon socially appropriate behavior for middle-class women.

The emergence of a commercial capitalist economy during the mid to late-nineteenth century facilitated an acceptance and increasing utilization of institutional sources of health care. Meanwhile, physicians sought to delineate and control a market for their services. In the process physicians acquired considerable influence in the hospital both as medical practitioners and as administrators. The latter role, however, was more common in the larger urban settings, and nursing matrons continued to administer small and rural hospitals.

The first training school for nurses emerged in 1874. While nursing leaders espoused the educational benefits of training, the schools functioned mainly as pools of cheap, controllable labour for the hospitals which supported their

existence. The nursing ranks were dominated by young, single, rural and urban lower-class women. It was women who sought training as nurses because of a lack of alternative employment opportunities, the room and board the hospitals provided, the family atmosphere that allegedly characterized hospital life, and because nursing tasks supported the conception that it was women's work.

While the development and expansion of training schools marked a period of transition in the history of nursing, the work demonstrated little actual change. It was still dominated by domestic labour, although some administrative tasks were also apparent. The conditions of work remained poor and the hours long. Many administrators also lengthened the period of training to three years from two to further secure a labour force for their institutions. By virtue of its control over the training school, the hospital exercised a considerable influence over its nurses. Furthermore, physician's expanding domination over health care extended into the training school, where the medical profession shaped the boundaries and content of nursing knowledge and practice.

While students were expected to follow the institution's rules, control of the labour force was still based upon the personal domination by the nursing superintendent. Increasingly, upper-level nursing staff attempted to reform the image of nurses and nursing by

enforcing the proper middle-class social qualities. Thus, the relations between nurses, and with physicians, administrators and patients were based upon class and gender appropriate behavior.

By the turn of the century paying patients entered into the hospital in increasing numbers. This change, and the poor financial outlook of most hospitals encouraged administrators to rationalize hospital management. Simultaneously, a more self-interested cadre of "professional" hospital administrators emerged. The orientation toward sound financial management, though, brought administrative objectives more into conflict with those of physicians and nurses.

The continued reliance upon and expansion of the apprenticeship system of nurses' training during the early twentieth century heightened the dissatisfaction of nursing leaders with the status of their "profession". The period was marked by their efforts to improve nursing education and achieve registration, two objectives that nursing leaders perceived to be requisites for nursing reform. However, the efforts of nursing leaders were constrained by their adherence to a maternal feminist ideology, and forced them to reject more direct and confrontational means to achieve change.

While the educational content of nurses' training process increased during this period, their work still

predominated and it was still comprised mainly of domestic tasks. The conditions of work began to change in a few institutions, although they were generally still difficult. The specialization of health care induced some specialization in nursing practice. Some nurses were no longer generalists, although this trend was limited to larger urban and specialized hospitals. The division of labour in the hospital had also expanded, as administrators sought to more effectively control a growing labour force. Although bureaucratic rules began to appear, control of nurses was still based upon the personal domination of nursing superintendents. Further, nurses' relationships to physicians, administrators and their nursing superiors continued to be influenced by middle-class social conventions regarding class and gender, appropriate behavior. Thus, even after nursing became work that women were trained and paid to do, it was still influenced by women's domestic role. Nursing was still women's work.

In short, the historical development of hospital-based nursing and its associated labour processes must be seen at two levels of analysis. At the societal level, women's labour force participation and their occupational distribution were shaped by commercial capitalist development, changing family relations and the predominant ideology. These factors also influenced the creation of hospital-based nursing as work. Thus one observes that

single urban and rural lower-class women entered nursing on the basis of their class and gender. As Reverby (1982) has argued, the history of nursing demonstrates how the ideological conditions of womanhood and the broader political-economic context created the conditions for nursing's development and changes in the labour process. These factors were still operative within the workplace, although the nursing labour process was influenced by factors particular to this level of analysis. More specifically, content of, and control over nursing practice was conditioned by the changing patient composition within hospitals, and the struggles between physicians, hospital administrators and nursing superintendents. Ultimately, however, it was still upon the basis of class and gender that the nursing labour process developed.

As I have attempted to argue, there are a number of factors that conventional nursing histories seem not to have discussed, that must be considered when analysing the historical development of nursing and its labour processes.

One such factor is the changing role of hospital administrators. Since nursing matrons managed the hospital on a day-to-day basis, administrators' influence was minimal during the early stages of hospital development. But their role increased significantly through the development of training schools, to a point where, in the early twentieth century, administrators influenced hospital

operations greatly. One must recognize how these changes, together with the demands of managing a hospital, led administrators to rely upon, and exploit the labour power of its nurses. Thus, throughout these periods it was always the labour demands of the institution that dictated the relative importance of education in the experiences of nurses.

One must also recognize that many nursing superintendents simultaneously functioned as hospital administrators, particularly in rural and smaller hospitals. As I have argued, this situation had a considerable impact upon the success of nursing reform. Nursing superintendents in the small rural and urban hospitals opposed nursing leaders' attempts to pass Bill 106 in 1906, and hence nursing reform because it conflicted with their responsibilities as administrators. It is apparent that these women elected to emphasize the needs of the hospital over those of nursing reform.

Further, the changing control of the medical profession over nursing and its work must be acknowledged. It has been argued that physicians had little real control over nurses and nursing prior to the development of training school. During the development of training school, however, physicians exercised administrative and intellectual (scientific) control in delimiting the boundaries of nursing practice, although by the beginning

of the twentieth century they had lost administrative control to "professional" non-physician administrators.

I have also discussed how the conflict within nursing influenced its development. Important here were the different interests of nursing leaders and the nursing superintendents of small urban and rural hospitals, and also the varied objectives of nursing leaders, and students and graduate nurses. Nursing leaders' aspirations of moral reform stood in stark contrast to the demands of nurses and the superintendents of the small urban and rural training schools, and consequently hindered real change at the level of the workplace by alienating their support.

What then, does this analysis suggest in terms of our theoretical orientation to questions concerning the labour processes of women's work?

As I have attempted to indicate throughout this discussion, an analysis of the labour process must be placed within a broader context. In the case of nursing, the outcome of the struggles between physicians, hospital administrators and nursing superintendents over the content and control of nursing as work, were due, in part, to wider social changes, which include the institutionalization of health care. Further, class and gender affected developments within the workplace and in society at large. In other words, the labour process is one part of an analysis that should take place at two levels of

abstraction.

Part of that broader social context in Ontario included the expansion of a scientific-technical ideology (cf. Lever and Jarrell, 1974; Sinclair et al., 1974). This ideology was manifest in the medical profession's struggle for dominance in health care, and hence also in their relationship to institutionalized health care, hospital administrators and nurses. Regarding the development of nursing, the medical profession's claim to scientific superiority effectively precluded nurses' attempt to independently influence the direction of health care practice, to which nursing leaders openly acquiesced. The claim by physicians to scientific superiority then, obscured their struggle to control medical practice by couching it in terms of scientific objectivity. Of course, the construction and legitimation of nursing as women's work was also affected by women's general exclusion from higher education and employment in the professions, and the conception of nursing care as "natural" for women, and hence non-scientific.

The uneven nature of social change is also apparent in this analysis. Just as urban economies first witnessed the growth of wage dependency, so too hospitals appeared first in urban centers. Further, the development of institutionalized health care, the emergence of medical dominance and "professional" administrators, as well as the

changes in nursing were too variable to be described as unilinear or even developments. For example, of it is precisely the uneven nature of urban and rural development that led to the conflict between nursing leaders and the nursing superintendents of the smaller hospitals. Thus, labour process analyses must remain cognizant of the potential variability and unevenness of change.

I have also pointed to some of the difficulties that result from the application of an orthodox marxian model of the labour process, particularly in terms of the relative conceptual significance of surplus extraction and gender. It appears as though public general hospitals did not fall under the logic of capital accumulation. This should not deny that economic concerns were relevant to struggles over nurses' control over their work.

Instead, changes in the labour process of hospital-based nursing should be seen as an interaction between gender and class. While the cheapness of women's labour can explain to some extent hospital trustee's reliance upon their labour as nurses, it cannot explain why women and not men that did this work. Further, the importance of gender as a basis for control over the nursing labour force, morality as skill, and as a factor in shaping superordinate-subordinate relationship between male administrators and physicians, and female nurses is not captured by concentrating on the relations between

(genderless) capital and labor. Merely to and assert the significance of gender does not obviate the difficulties of theorizing the relationship of gender to class, to which a large amount of feminist work testifies. Nonetheless, even while recognizing these difficulties we need to make a more concerted attempt to do so.

This analysis has also indicated that in order to more fully understand nursing history and changes in the labour process, a broad range of areas related to nursing and institutionalized health care need to be examined in more detail.

Craig (1985-1986) has indicated that institutional histories abound in the Canadian historical literature, although there is, as yet, no integrated history of hospitals in Ontario. This gap needs to be addressed in order to assess better the changing role of nurses within the hospital, and the changing relationships between nurses, physicians, hospital administrators and the other occupational groups that emerged later. Particularly lacking is a detailed discussion of the social relations between physicians and nurses during the period in which institutionalized health care was not widespread and physicians did not play an important role in hospital-based care.

The continued importance of private duty nursing through the late-nineteenth and early twentieth centuries

suggests that the this aspect of nursing also requires considerable attention. The issue of why graduate nurses did not work in hospitals is of special importance. What were the relative influences of their structural exclusion from hospital-based nursing, and, as Reverby (1982) indicates, their preference for the independence of private duty nursing, despite its more tenuous economic nature? Only when we understand why graduate nurses did not work in hospitals can we explain their later movement into them.

The emerging influence of a relatively small group of middle-class nursing leaders also points to the importance of nursing organizations as a vehicle for change, here the GNAO. What this analysis did not attempt to do was to engage in a detailed assessment of the organization and activities of the GNAO, or any of the other nursing associations for that matter. Such an analysis needs to be undertaken, not only of provincial organizations, despite their obvious importance in a country where health care is a matter of provincial jurisdiction, but also of individual alumnae associations, national nursing organizations such as the Canadian National Association of Trained Nurses and the Canadian Society of Superintendents of Training Schools for Nurses, and international associations such as the International Council of Nurses. In other words, a more complete examination of the role of nursing organizations in the project of nursing reform needs to be undertaken.

The influence of the broader social context upon the development of the nursing labour process indicates that more attention also needs to be directed towards an examination of the linkages between nursing reform and the women's movement. For example, did the National Council of Women in Canada, as Riddell (1970) indicates, have any role in nursing reform? How did their objectives with respect of the women's movement relate to nursing leader's agenda for change? As an analysis of hospital-based nurses in British Columbia implies (Warburton and Carroll, 1986), the relationship between nursing and the labour and feminist movements are relevant to our understanding of the relative influences of class and gender upon nurses.

Further, Graham maintains that:

the experience of caring is the medium through which ...women gain admittance into both the private world of the home and the public world of the labour market. It is through caring in an informal capacity - as mothers, wives, daughters, neighbours, friends - and through formal caring - as nurses, secretaries, cleaners, teachers, social workers - that women enter and occupy their place in society (1983:30).

Thus, it is upon this basis that more attention needs to be directed toward nursing, particularly if it is to be understood as a case study of women's oppression (Bullough and Bullough, 1978).

**APPENDIX A: LEGISLATION RELEVANT TO HOSPITALS,
1833-1931**

Date	Legislation (Auspices):	Objectives/Significance
1833	Public Health Act (Ontario):	Established Board of Health when necessary to protect against communicable disease
1849	Public Health Act (Ontario):	Empowered Governor to appoint Board of Health when necessary
1867	British North America Act (Federal):	Delegated jurisdiction to provinces for and education health care
1873	Public Health Act (Ontario):	Authorized municipalities to create local Board of Health to scrutinize public health when required
1874	Charity Aid Act (Ontario):	Systematized per diem funding to hospitals which were differentiated by function
1879	Orderin Council (Ontario):	Limited aid to indigent patients to 270 days
1882	Public Health Act (Ontario):	Created provincial Board of Health with medical representation
1884	PublicHealth Act (Ontario):	Required incorporated places to establish Board of Health
1900	Amendment:CharityAid Act (Ontario):	Provided \$100,000 pro ratio funding to schedule A (public) hospitals on basis of the number of patient days

Date Legislation (Auspices): Objectives/Significance

1895 Hospitals and Charitable

Institutions Act (Ontario): Decreased aid to indigent patients to 120 days, revoked aid to patients able to pay for their care, and delineated municipal responsibilities for hospital funding

1897 Hospitals and Charitable

Institutions Act (Ontario): Revoked per diem funding provisions of 1895 Act

1912 Hospitals and Charitable

Institutions Act (Ontario): Provided funds for hospitals regulated by as able to establish training schools for nurses

1912 Public Health Act (Ontario): Amalgamated previous public health

legislation, returned to per diem payments to hospitals

1931 Public Hospitals Act (Ontario):

Restricted grants to approved hospitals and established hospital standards

Sources: The Hospitals Division of the Department of Health (1934), The Hospitals of Ontario: A Short History. Mandell, Nancy P. (1974), Social Change and the Medical Profession: Whither the Professional Role?; Moscovitch, Allan (1983), The Welfare State in Canada: A Selected Bibliography, 1840-1978.; Splane, Richard B. (1965), Social Welfare in Ontario: 1791-1893: A Study of Public Welfare Administration. Wallace, Elisabeth (1980), "The Origin of the Social Welfare State in Canada, 1867-1900."

APPENDIX B: RELEVANT MEDICAL LEGISLATION, 1818-1912

Date Legislation (Auspices): Objectives/Significance

1818 Upper Canada Medical Act

(Ontario): Established Medical Board,
asserted no one should
practice without a licence

1827 UpperCanada Medical Act

(Ontario): Required registration and
licencing for all
practitioners except midwives
and military practitioners,
set penalties for illegal
practice

1859 ----- (Ontario):

Recognized existence of
Homeopaths, allowed them to
establish their own Board
of Examiners.

1861 ----- (Ontario):

Recognized existence of
Eclectics, allowed them to
establish their own Board
of Examiners

1865 Ontario Medical Act (Ontario):

Created General Council of
Medical Education and
Registration with
representation of
practitioners and medical
educators, established
curricula, granted licences,
created medical register

1867 British North America Act (Federal):

Delegated jurisdiction to
provinces for health care
and education: made medical
legislation a provincial
matter

1869 Ontario Medical Act (Ontario):

Formally recognized
Homeopaths and Eclectics
as medical practitioners,
eliminated discrepancies in
education and licencing
between allopaths and
non-allopaths

Date Legislation (Auspices): Objectives/Significance

1874 Ontario Medical Act (Ontario):

Dealt with the fulfillment
of educational requirements
for Homeopaths

1887 Ontario Medical Act (Ontario):

Increased disciplinary
provisions

1912 Canada Medical Act (Federal):

Standardized medical
registration nationally

Sources: Gidney, R.D., Millar, W.P.J. (1984), "The Origins of Organized Medicine in Ontario, 1850-1869."; Hamowy, Ronald (1984), Canadian Medicine: A Study in Restricted Entry; MacNab, Elizabeth (1970), A Legal History of the Health Professions in Ontario; Mandell, Nancy P. (1974), Social Change and the Medical Profession: Whither the Professional Role?.

APPENDIX C: LEGISLATION RELEVANT TO NURSING

Date Legislation (Auspices): Objectives/Significance

1867 British North America Act (Federal):

Delegated jurisdiction to provinces for health care and education: made nursing registration a provincial matter

1912 Hospitals and Charitable Institutions Act (Ontario):

Allowed hospitals funded under the Act to establish training schools for nurses

1922 Registration of Nurses Act

(Ontario): Set conditions for the establishment of training schools for nurses, entitled graduates to register established penalties for use of the title "Graduate Nurse" unless registered

Sources: MacNab, Elizabeth (1970), A Legal History of the Health Professions in Ontario; Registered Nurses' Association of Ontario (1963), "Interpretive Information in Respect to the History, Organization and Activities of the RNAO."; Wallace, Elisabeth (1980), "The Origin of the Social Welfare State in Canada, 1867-1900."

ENDNOTES

¹ See also Davies (1980) and Lynaugh and Reverby (1987) for a more general discussion of some of the difficulties with conventional nursing histories.

² Throughout the remainder of this thesis institutionalized will refer simply to the shift to institutional forms of care, such as hospitals, versus a continuing reliance upon the self, family and community.

³ The work of Ashley (1976), Melosh (1982) and Reverby (1982) on the United States is also notable.

⁴ I limited the discussion to 1922 in an effort to delimit suitable boundaries for a thesis of this scope. The Nurses' Registration Act of 1922 provides an opportunity to make a "clean" temporal break in the discussion.

⁵ For example, the earlier settlement of New France by French immigrants, and the more pervasive influences of the nursing orders, and hence religion, in Lower Canada (Quebec) make its early history vis-a-vis health care and nursing quite different from that of Upper Canada (Gibbon and Mathewson, 1947).

CHAPTER 2

¹ For a contemporary elaboration of Marx on this topic, see Carchedi (1975) and Clement (1983a,b).

² Thompson cautions that efforts to broaden its scope of applicability beyond relations of domination dissolves "the connection between the concept of ideology and the critique of domination" (1983:165).

³ In The German Ideology Marx and Engels (1947) posit that sex constituted the first division of labour. While this is an important recognition, their statement has generated considerable opposition from feminists because of the assumption by Marx and Engels that the division of labour was predicated upon the act of childbearing - biology - and not social factors (Eisenstein, 1979).

⁴ There is also an important political consequence of the failure to recognize the importance of gender. By maintaining the primacy of class struggle means that the transition to communist society would leave women's oppression intact (Barrett, 1980; Jaggar, 1983).

⁵ It seems inappropriate to apply the concepts formal and real subordination owing to the charitable status of most Ontario hospitals. In contrast to the American situation (Reverby, 1982), most hospitals were not oriented to

generate surplus value, although they later rationalized business practices to improve their economical viability. One cannot then speak of the formal and real subordination of labour (nurses) to capital (hospital administrators). Nonetheless, the concepts are useful by orienting attention in the labour process to the issues of control, the division of labour, deskilling and technology. Thus, while not explicitly applying the concepts, they will implicitly frame the discussion. My broader use of the term subordination, then, will denote the subjugation of nursing to external agencies of control.

CHAPTER 3

¹ The discussion of economic changes will draw upon the work of Aitken (1967), Clement (1974), Cross and Kealey (1982), Firestone (1960), McCalla and Peter (1986), and Spelt (1972).

² Katz, Doucet and Stern (1982) emphasize the importance of differentiating capitalism - the social organization of production - from industrialization - the process or the transformation of human labour via the use of inanimate source of energy in factory based production. Thus, while a mercantile capitalist economy had existed in Canada since the eighteenth century (Clement 1974), it was only with industrial capitalism in the mid-nineteenth century that industrialization began to take hold (Cross and Kealey, 1982; Firestone, 1960; Spelt, 1972).

³ My use of rationality, rationalize and rationalization will convey meaning at two levels. At the most abstract level it will refer to the dominance of instrumental (vis-a-vis symbolic inter) action as facilitated by scientific-technical progress (cf. Habermas, 1970). At a lesser level of abstraction, the terms will be used to describe a particular manifestation of this domination within the workplace as characterized by a more bureaucratic form of administration, and the attempt by management to gain more control over the labour process (such as through deskilling, job decomposition, and mechanization) (see Braverman, 1974).

⁴ In discussing the family it is important to distinguish between the family and household (Katz, 1975; Katz, Doucet and Stern, 1982). This discussion will be based upon the work of Gaffield (1984), Gagan (1981), Johnson (1974), Katz (1975), Katz, Doucet and Stern (1982), Light and Prentice (1980), and Nett (1981).

⁵ In 1851 the crude birth rate in Canada was 46 per 1000 women, while the mean births per woman was 7.02. Life expectancy at age twenty was 39.6 years for males and 41.4 for women (Beaujot and McQuillan, 1986). Families were also

generally larger in rural areas.

⁶ Johnson (1974) and Katz (1975) point out that the capitalist and merchant class was not a homogeneous group. Many capitalist and merchant families were not financially well-off, and thus, not all had hired servants. As a result, the role of women and children in these families was somewhat varied. Some wives and children were forced to engage in domestic labour, and/or seek paid employment.

⁷ By 1921 the crude birth rate had declined to 29.3 per 1,000, the number of births per woman dropped to 3.54, and life expectancy at the age of twenty had increased to 45.1 years for males and 47.5 for females (Beaujot and McQuillan, 1986).

⁸ The historical data on women's labour force participation is largely incomplete. While the first census was taken in 1851, employment statistics concerning women were not systematically collected until 1891. Even then they must have considerably underestimated women's LFP rates because the concept of gainful employment which was used did not take into consideration whether one was working part-time or only intermittently (Chen and Regan, 1985). The data is also problematic because of definitional changes, a lack of standardization in early records, changes in occupational categorizations, sex-biasing of those categories, and a failure to categorize multiple job holdings (Armstrong and Armstrong, 1983; Wilson, 1982). The result is that we have an incomplete picture that underestimates women's labour force participation.

While my discussion concerns women's employment in Ontario, I am using Canadian data owing to the paucity of employment statistics specific to Ontario, the close parallels between female's LFP rates in Canada and Ontario (see Table 3), and the centrality of economic developments in Ontario vis-a-vis the remainder of Canada.

⁹ In her 1892 report, Scott notes that wages varied within and between industries. In factories wages averaged \$2-3 per week, with a few earning up to \$10-14 per week. However, women's wages were lower than those of the male workers. Scott also notes that general domestics earned \$12-14 per month, cooks \$12-20 per month, housemaids \$8-12 per month, nurses \$8-12 per month, seamstresses \$14 per month, and laundresses \$16 per month. Female teachers averaged \$296 per year, considerably less than the average \$421 per year earned by men.

CHAPTER 4

¹ Churches played an important role in Upper Canada, particularly as an impetus for humanitarian action (Glazebrook, 1968; Splane, 1965). In fact, it was largely

through the efforts of the Roman Catholic Church, both the French Roman Catholics from Lower Canada (Gibbon and Mathewson, 1947) and those from the British Isles (CNA, 1968; Glazebrook, 1968), that some of the hospitals were built in Upper Canada (Campbell, 1984; Gibbon and Mathewson, 1947; Paul-Emile, n.d.; St. Joseph's School of Nursing, n.d.). The Protestant churches, on the other hand, acted more informally in their support of these institutions. While accepting the import of religious-based hospitals in the development of institutionalized health care, they will not be discussed here because of space limitations, and because they require a separate analysis.

A clarification also needs to be made regarding the use of public general hospitals. My use of the term reflects that of the Hospitals Division of the Department of Health (1934). The Ontario government used the designation to refer to institutions that served the general public including charity (non-paying) patients, and were not specialized in function, criteria that were used to determine if the hospital was eligible for funding. It must be pointed out that many denominational hospitals could technically be classified as general public hospitals, but were not because of their denominational affiliations. As the term is used here then, public general hospitals are non-denominational.

² Langmuir's recommendations were based upon the belief that hospitals should provide relief for the sick-poor who would otherwise be dependent upon public support or charity. His report required that for hospitals to be eligible for funding they would have to assure that 60 percent of all hospital beds would be reserved for the indigent.

³ Habermas (1970) points out that the increasing productivity and domination over nature, which increases individual comforts, obscures the oppressive nature of this scientific rationality.

⁴ Further, as indicated earlier the educational requirements for homeopaths and eclectics continued to differ from those of the regulars, even after the 1865 Ontario Medical Act. It was not until 1869 that the Ontario Medical Act eliminated those discrepancies (Gidney and Millar, 1984; Hamowy, 1984).

⁵ One must recall that women were largely structurally excluded from access to scientific study because of the relative inaccessibility to university education.

⁶ Runnalls (1974) notes that St. Catharines hospital by-laws indicated the hospital routine was to be adhered to, except when it conflicted with the directives of the attending physician.

7 The records of the County of Carleton General Protestant Hospital of Ottawa (1902, 1904, 1906, 1908, 1910, 1911, 1920) clearly reflect this trend. From the turn of the century to 1920 one notes an increase in the number of patients being treated, the number of paying patients entering the hospital and a concomitant growth in the percentage of total hospital revenues generated from that source, a systematization of government funding, but a continual state of debt.

CHAPTER 5

1 The historical literature concerned with hospital-based care is replete with physician's objections to nurses' independence within the hospital (see Clarke, 1913; Cosbie, 1975; Macbeth, 1959).

CHAPTER 6

1 The Lady Stanley Institute in Ottawa was one notable exception. Although affiliated with the County of Carleton General Protestant Hospital, it was independently funded until the formation of the Ottawa Civic Hospital in the 1920's forced a merger of the training school and three other hospitals (Gibbon and Mathewson, 1947).

2 The observation that many of the pioneer nurses that developed training schools in Ontario were trained in the United States is an important one, for reasons that will become apparent later on. Examples of this include Jean Gunn (Roberts and Tunnell, 1936), Mary Agnes Snively, Nora G.E. Livingston and Louise C. Brent (Morgan, 1912).

3 The existing literature is unclear on which students were availed of these administrative positions. It is apparent, though, that the graduates of the more prestigious training schools, which were also more selective of the students they accepted, and hence were also more likely to have students of "suitable" (ie. middle-class) character, obtained positions as nursing superintendents in the larger, urban hospitals.

4 One would expect that, given the considerable control nurses and other senior hospital staff wielded over the patient, individuals who could afford to be treated at home might still do so because of the control they could wield over the nurse within their own home. The problem of the relationship of nurses to the families they nursed was frequently of concern in the pages of The Canadian Nurse.

5 "Special" cases were those in which the patient, mostly wealthy, directly hired a nurse for care within the hospital, instead of "sharing" a nurse with other patients.

6 Reverby (1982) makes the point that the constant discipline and rigid hierarchy was a necessity given pupil's lack of knowledge and skills in patient care.

7 Professor G. Irving suggested this possibility to me.

8 In specialty hospitals the range of training experience was further affected because of the limited nature of their clientele. In tuberculosis sanatoriums for example, students had little contact with other diseases.

9 It is interesting to note that, at the same time as nurses were advocating increasing the time in training devoted to lectures, there was some evidence within the medical profession of an attempt to shift medical education in the other direction (Editors, 1890; Godfrey, 1979; MacNab, 1970; Ogden, 1879; see Chapter Four). That is, some physicians asserted that there was too much time spent in lectures, and too little in practical, hospital-based teaching.

CHAPTER 7

1 Gibbon and Mathewson (1947) note that in 1900 only 20 training schools existed in Canada, expanding to 70 in 1909.

2 A perception existed that growing numbers of patients capable of paying for private wards and care by private physicians were entering public wards physician's care was free and rates for hospital care were considerably lower (Decker, 1923; "Practitioner", 1908; Wilson, 1900; Young, 1899). Physicians and administrators were both reacting to a potential loss of revenue by criticizing the practice.

3 Mary A. Catton instituted a "Court of Honor Pledge" when she became nursing superintendent: a pledge that embodies intense institutional loyalties fostered during the training period (MacBeth, 1959; see also Melosh, 1982; Reverby, 1982).

Court of Honor, Lady Stanley Institute
We'll do right, or we'll know why
For we are honor bound
To the Lady Stanley Institute

4 In 1893 the American Society of Superintendents of Training Schools (ASSTS) was formed, and in 1896 also the Nurses Associated Alumnae (NAA) (Melosh, 1982; Reverby, 1982). These were comprised largely of Canadian and American nursing superintendents from prominent training schools and hospitals. In 1907 the Canadian Society of Superintendents of Training Schools for Nurses (CSSTSN)

formed, and in 1908 the Canadian National Association of Trained Nurses (CNATN) organized (Gibbon and Mathewson, 1947). The latter, although intended to represent the interests of trained nurses - like the NAA - was organized by many of the same nursing superintendents that comprised the CSSTSN, some of whom were also active in the ASSTS and NAA.

5 The organizational linkages of many nursing superintendents goes beyond merely these two organizations. For example, Miss Mary Agnes Snively, trained in Bellevue Hospital in New York, later became the superintendent of the Toronto General Hospital, was a member of the Executive Committee of the Graduate Nurses Association of Ontario (GNAO) in 1905, in 1910 the president of the CNATN, and in 1913 a councillor of the CSSTSN. Miss Jean Gunn was trained in Presbyterian Hospital in New York, became Superintendent of the Toronto General Hospital in 1913 (after Snively resigned), was for six years President of the CNA, was also the editor of the Canadian Nurse, as well as secretary and treasurer of the CNATN in 1916 and 1917 respectively and councillor of the CSSTSN from 1916 to 1917. Miss Bella Crosby, trained at the Toronto General Hospital, was also an editor of the Canadian Nurse, correspondence secretary of the GNAO in 1905, and also its President in 1911 and 1913. Miss Louise Brent, trained at the Brooklyn City Hospital in New York, and superintendent at the Grace Hospital and Hospital for Sick Children, both in Toronto, was also President of the Canadian Hospital Association in 1907, President of the CSSTSN in 1909 and also its treasurer in 1912, as well as being First Vice-President and Director of the GNAO in 1906. Many other such linkages could also be made.

6 The GNAO recommended that the council be constituted by four physicians and eleven nurses who were also GNAO members. Physicians and hospital administrators made a counter-proposal that would see the council made up of four physicians, four hospital administrators and seven nurses (Knisely, 1926; MacNab, 1970).

7 For Dickson (1923) the key differentiation between the two settings lay in the type of patients they served and hence the degree of supervision afforded thereby. She found rural hospitals to have a higher proportion of private patients than large urban hospitals. This meant that in former most of the nurses' experience would be obtained on private wards, while in the latter the opposite obtained. Dickson held that a predominance of private patients, being located in private rooms, did not allow sufficient supervision by a student's superiors, thereby threatening a patient's safety, a situation that she believed was less likely in public wards.

8 The problem of marriage was widely recognized among nursing superintendents, who maintained that marriage was a major source of labour force participation intermittancy among nurses...an observation that did not merely apply to nursing, however. Work was still, for most working-class women, an interlude between childhood and marriage. For single middle-class women, though, the rejection of marriage provided the potential to pursue a career. In this way, nursing superintendent's unique middle-class perspective blinded them to working-class women's reality.

9 Moreover, instead of eliminating the competition of untrained nurses, Hodgins recommended the formation of another category of nurses; practical nurses (Hodgins, 1918; Riddell, 1970). Since hospitals objected to the necessity of hiring graduate nurses partly on the basis of their higher wages, Hodgins reasoned that a category of workers below graduate nurses - being paid lower wages - would be an acceptable compromise. Hospital administrators approved, recognizing that a lower-paid and potentially more submissive labour force would be created. Nursing leaders objected, fearing competition from this lower-paid category of "nurses" (Coburn, 1974), and one might suspect also the potential damage a new lower class of nurses might do to the "professional" image of nursing. Nonetheless, they were forced to accede, instead asserting the necessity of controlling their education as an attempt to preclude the possibility of this new category of workers competing with trained nurses.

10 Even if there had been no restriction on labour's activities during the war, hospitals were in no position to grant concessions. Finances were even more limited than usual, and hospitals were prevented from charging higher rates to public ward patients by the government (MacPhail, 1914), further constraining their ability to make ends meet economically.

REFERENCES

- Agnew, G. Harvey
 1974 Canadian Hospitals, 1920 to 1970. A Dramatic Half Century. Toronto: University of Toronto Press.
- Aikens, Charlotte A.
 1907a "The Head Nurse." *The Canadian Nurse* 3(2):51-4.
 1907b "The Head Nurse and Her Patients." *The Canadian Nurse* 3(3):130-4.
 1907c "Hospital Ethics and Discipline." *The Canadian Nurse* 3(4):191-3.
 1907d "Hospital Ethics and Discipline." *The Canadian Nurse* 3(5):247-9.
 1907e "Hospital Ethics and Discipline." *The Canadian Nurse* 3(6):313-6.
 1908 "Canadian Nurses and the American Hospital Association." *The Canadian Nurse* 4(4):164-5.
- Aitken, Hugh G. J.
 1967 "Defensive Expansion: The State and Economic Growth in Canada." in Approaches to Canadian Economic History, W.T. Easterbrook, M.H. Watkins (eds.), Toronto: McClelland and Stewart.
- Alumnae Association of the Nicholls Hospital, The
 n.d. Peterborough, Ontario: The Nicholls Hospital.
- Angus, Margaret
 1973 Kingston General Hospital: A Social and Institutional History. Montreal: McGill-Queen's University Press.
- An Ex-Private Duty Nurse
 1923 "The Private Duty Nurse and the Association." *The Canadian Nurse* 19(2):101-2.
- Anonymous
 1905 "From an Ontario Hospital." *The Canadian Nurse* 1(3):29.
 1907 "A Residence for Nurses - Description of the New Building Erected in 1906 for the Nurses of the Hospital for Sick Children, Toronto." *The Canadian Nurse* 3(1):79.
 1910 "The C.H.A.." *The Canadian Nurse* 6(5):189-91.

- Apthias, Floya and Yuval-Davis, Nira
1983 "Contextualizing Feminism - Gender, Ethnic and Class Divisions." *Feminist Review*, 15 (November): 62-75.
- Armstrong, Pat., Armstrong, Hugh
1983 "Beyond Numbers: Problems with Quantitative Data." in Women and Work, May Kennear, Greg Mason (eds.), Ottawa: SSHRC.
- Ashley, Jo Ann
1976 Hospitals, Paternalism and the Role of the Nurse. New York: Teachers College Press.
- Ball, Rosemary R.
1975 "'A Perfect Farmer's Wife': Women in Nineteenth Century Rural Ontario." *Canada: An Historical Magazine* 3 (1975): 2-21.
- Baly, Monica E.
1986 Florence Nightingale and the Nursing Legacy. London: Broom Helm.
- Barrett, Michele
1980 The Oppression of Women Today. London: Verso.
- Bassett, Isabel
1975 The Parlour Rebellion: Profiles in the Struggle for Women's Rights. Toronto: McClelland and Stewart Ltd.
- Beaujot, Roderic P. and McQuillan, Kevin
1986 "The Social Effects of Demographic Change: Canada 1851-1981." *Journal of Canadian Studies*, 21(1): 57-69.
- Beechey, Veronica
1982 "The Sexual Division of Labour and the Labour Process: A Critical Assessment of Braverman." in The Degradation of Work? Stephen Wood (ed.), London: Hutchinson.

1977 "On Patriarchy." *Feminist Review* 3: 66-72.
- Belleville General Hospital
n.d. "Belleville General Hospital School of Nursing, 1893-1978: Historical Information." Belleville, Ontario: Belleville General Hospital.
- Benton, Ted
1984 The Rise and Fall of Structural Marxism: Althusser and His Influence. New York: St. Martin's Press.

- Biggs, C. Lesley
1983 "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900." Ontario History 75(1):21-35.
- Bilson, Geoffrey
1984 "'Muscles and Health': Health and the Canadian Immigrant, 1867-1906." in Health, Disease and Medicine: Essays in Canadian History, Charles G. Roland (ed.), Hamilton: The Hannah Institute for the History in Medicine.
- Blythe, Jean L.
1919 "The Nurse and Her Work." The Canadian Nurse 15(10):2052-5.
- Botting, J.F.
1912 "What is a Nurse." The Canadian Nurse, 8(12):655-62.
- Bouchard, Jeannette
1984 Seven Decades of Caring. Sudbury, Ontario: Laurentian University Press.
- Bowerman, Lucy
1906 "Correspondence." The Canadian Nurse, 2(2):50.
1907a "Correspondence." The Canadian Nurse 3(2):77.
1907b "Registration for Nurses." The Canadian Nurse 3(3):153-6.
- Bowman, Miss.
1912 "Registration." Presented at the Sixth Annual Meeting of the Canadian Society of Superintendents of Training Schools for Nurses, May 23, Hamilton, Ontario.
- Boyd, H.A.
1909 "The Evolution of Surgical Technique during the Last Half Century." The Canadian Nurse, 5(5):233-5.
- Bradby, Barbara
1982 "The Remystification of Value." Capital and Class, 17(Summer):114-33.
- Braverman, Harry
1974 Labor and Monopoly Capital. New York: Monthly Review Press.

- Breay, Margaret
1913 "The Overstrain of Nurses." *The Canadian Nurse*,
9(3):153-7.
- Bull, W.P.
1934 From Medicine Man to Medical Man. Toronto: George
J. McLeod Ltd.
- Bullen, John
1986 "Hidden Workers: Child Labour and the Family
Economy in Late Nineteenth-Century Urban Ontario."
Labour 18(Fall):163-87.
- Bullough, V.L., Bullough, B.
1978 The Care of the Sick: The Emergence of Modern
Nursing. London: Croom Helm.
- Burawoy, Michael
1985 The Politics of Production. London: Verso.
1979 Manufacturing Consent: Changes in the Labor
Process under Monopoly Capitalism. Chicago:
University of Chicago Press.
- B L.
1908 "General Apathy." *The Canadian Nurse* 4(9):438-40.
- Cameron, Janet E.
1915 "Management of Small Hospitals." *The Canadian
Nurse* 11(2):69-73.
- Cameron, Professor Irving
1922 "The Nurses' Life and Calling." *The Canadian Nurse*
18(10): 636-42.
- Campbell, George
1984 The Spirit, the Lamp, and the Key. Thunder Bay:
St. Joseph's General Hospital.
- Campbell, Marjorie Freeman
1956 The Hamilton General Hospital School of Nursing,
1890-1955. Toronto: The Ryerson Press.
- Canadian Nurse, The
1916 "Editorial: Nurse Education." *The Canadian Nurse*
12(2):88-92.
- Canadian Nurses Association (CNA)
1968 The Leaf and the Lamp. Ottawa: Canadian Nurses
Association.

- Canadian Red Cross Society
1921 "Is There a Shortage of Student Nurses?" The Canadian Nurse 17(10):631-6.
- Carchedi, Guglielmo
1975 On The Economic Identification of Social Classes. London: Routledge and Kegan Paul.
- Carter, L.J.
1921 "Some Present Day Problems of the Nursing Profession." The Canadian Nurse 17(3):147-53.
- Cassidy, J.J. (ed.)
1897 "The Toronto General Hospital School For Nurses." Canadian Journal of Medicine and Surgery 1(2):77-9.
- Chappell, F., Beaton, J.H., Telford, G., Bapty, Walter
1956 The Hospital and the Lamp. Oshawa, Ontario: Oshawa General Hospital.
- Chen, Mervin Y.T., and Regan, Thomas G.
1985 Work in the Changing Canadian Society. Toronto: Butterworths.
- Chesley, Miss
1909 "How to Foster the True Spirit of Nursing to Combat the Commercial." The Canadian Nurse, 5(10):695-8.
- Clarke, C.K.
1913 A History of the Toronto General Hospital. Toronto: Ryerson Press.
- Clawson, Dan
1980 Bureacracy and the Labor Process: The Transformation of U.S. Industry, 1860-1920. New York: Monthly Review Press.
- Clement, Wallace
1983a "The Subordination of Labour in Canadian Mining." in Class Power and Property: Essays on Canadian Society. Toronto: Methuen.
1983b "Property and Proletarianization: Transformation of Simple Commodity Producers in Canadian Farming and Fishing." in Class Power and Property: Essays on Canadian Society. Toronto: Methuen.

- 1974 "The Changing Structure of the Canadian Economy." in Aspects of Canadian Society, Raymond Breton (ed.), Montreal: Canadian Review of Sociology and Anthropology.
- Coburn, C.
 1981 "'I See and am Silent': A Short History of Nursing in Ontario." in Health and Canadian Society: Sociological Perspectives, D. Coburn, C. D'Arcy, P. New, G. Torrance (eds.), Toronto: Fitzhenry and Whiteside.
- 1974 "'I See and am Silent': A Short History of Nursing in Ontario." in Women at Work, Ontario 1850-1930. Janice Acton, Penny Goldsmith, Bonnie Shepard (eds.), Toronto: Women's Educational Press.
- Cockburn, Cynthia
 1983 Brothers: Male Dominance and Technological Change. London: Pluto Press.
- Connelly, Patricia
 1978 Last Hired, First Fired: Women and the Canadian Work Force. Toronto: The Women's Press.
- Cook, Ramsay and Mitchinson, Wendy (eds.)
 1976 The Proper Sphere: Woman's Place in Canadian Society. Toronto: Oxford University Press.
- Cosbie, W.G.
 1975 The Toronto General Hospital, 1819-1965: A Chronicle. Toronto: MacMillan of Canada.
- County of Carleton General Protestant Hospital of Ottawa
 1902 "Fifty-First Annual Report, 1901." Ottawa: James Hope and Sons, Printers.
- 1904 "Fifty-Third Annual Report, 1903." Ottawa: The Rolla L. Crain Company, Limited.
- 1906 "Fifty-Fifth Annual Report, 1905." Ottawa: The Rolla L. Crain Company, Limited.
- 1908 "Fifty-Seventh Annual Report, 1907." Ottawa: The Rolla L. Crain Company, Limited.
- 1910 "Fifty-Ninth Annual Report, 1909." Ottawa: Copeland-Chatterson-Crain, Limited.
- 1911 "Sixtieth Annual Report, 1910." Ottawa: Copeland-Chatterson-Crain, Limited.

1920 "Sixty-Ninth Annual Report, 1919." Ottawa:
Copeland-Chatterson-Crain, Limited.

Craig, Barbara Lazenby

1985 /- "The Canadian Hospital in History and Archives."

1986 Archivaria 21:52-67.

Craig, Barbara Lazenby and Macleod, Ronald K.

1984 A Separate and Special Place. Toronto: The Queen
Elizabeth Hospital.

Crosby, Bella

1915a "Editorial: Criticism." The Canadian Nurse
11(1):29-30.

1915b "Gleanings: Is Nursing a Profession of a Trade?"
The Canadian Nurse 11(9):504-5.

Cross, Michael S. and Kealey, Gregory S. (eds.)

1982 "Introduction to Volume 3." in Canada's Age of
Industry, 1849-1896. Readings in Canadian Social
History, Volume 3. Toronto: McClelland and Stewart.

CSE Sex and Class Group

1982 "Sex and Class." Capital and Class, (Spring):78-
94.

Davey, Ian E.

1975 "Trends in Female School Attendance in Mid-
Nineteenth Century Ontario." Social History
8(16):238-54.

Davies, Celia (ed.)

1980 "Introduction: The Contemporary Challenge in
Nursing History." in Rewriting Nursing
History, London: Croom Helm.

Decker, C.J.

1923 "The Hospital - Its Problems." The Canada Lancet
and National Hygiene 62(3):81-8.

Dickson, E. Macpherson

1923 "Report of the Inspector of Training Schools in the
Province of Ontario." Toronto.

Dominion Bureau of Statistics

1873 Census of Canada, 1870-71. Volume II, Ottawa:
I.B. Taylor.

1884 Census of Canada, 1880-81. Volume II, Ottawa:
MacLean, Roger and Company.

- 1893 Census of Canada, 1891. Volumes II, IV, Ottawa:
S.E. Dawson.
- 1906 Fourth Census of Canada, 1901. Volume IV, Ottawa:
Census Office.
- 1915 Census of Canada, 1911. Volume IV, Ottawa:
Department of Trade and Commerce.
- 1929 Census of Canada, 1921. Volume IV, Ottawa:
Bureau of Statistics.
- 1936 Seventh Census of Canada. Volume VII, Ottawa:
Dominion Bureau of Statistics.

Duncanson, Blanche

- 1970 "The Development of Nursing Education at the Diploma Level." in Nursing Education in a Changing Society, Mary Q. Innis (ed.), Toronto: University of Toronto Press.

Eastwood, Charlotte E.

- 1907 "State Registration." *The Canadian Nurse*, 3(1):9-11.

Editor

- 1877 "School for Training Nurses." *The Canada Lancet* 9(11):345.
- 1885 "Trained Nurses." *The Canada Lancet* 18(4):120.
- 1879 "Training School for Nurses." *The Canada Lancet* 11(5):154.
- 1888 "Trained Nurses." *The Canada Lancet* 20(8):251-2.
- 1903 "Evaluation of Nurses." *The Canada Lancet* 37(2):157-8.
- 1905 "The Trained Nurse." *The Canada Lancet* 39(4):365-6.
- 1907 "Ontario Government Aid to Hospitals." *The Canada Lancet* 40(9):774-9.

Editors

- 1883 a "Medical News." *The Canadian Practitioner* 8(September):282.
- 1883b "Medical News: Nursing." *The Canadian Practitioner* 8(November):326-7.

- 1890 "Nurses and Doctors." The Canadian Practitioner 15 (April):164-5.
- 1891 "Education of Girls." The Canadian Practitioner 16 (June):261.
- 1892 "Higher Education for Women." The Canadian Practitioner 17 (June):257-60.
- 1897 "Lady Nurses." The Canadian Practitioner 22 (August):613-4.
- 1898 "Lengthened Courses for Nurses." The Canadian Practitioner 23 (February):113-4.
- 1905 "The Modern Nurse." The Canadian Practitioner 30 (January):32-3.
- Edy, L.M.
1920 "The Eight-Hour Day For Nurses." The Canadian Nurse 16 (3):133-6.
- Ehrenreich, B., English, D.
1973 Witches, Midwives and Nurses: A History of Women Healers. New York: The Feminist Press.
- Eisenstein, Z.R. (ed.)
1979 "Developing a Theory of Capitalist Patriarchy." in Capitalist Patriarchy and the Case for Socialist Feminism, New York: Monthly Review Press.
- Ellis, Elizabeth E.
1909 "New Methods in Surgical Nursing." The Canadian Nurse, 5 (12):7-11.
- Ewing, Margaret
—1915—"Toronto Central Registry of Graduate Nurses." The Canadian Nurse 11 (8):436-9.
- Falcon, Nicholas Coyle
1984 An Examination of the Conditions Surrounding the Subordination of Nursing Labour in Canadian Hospitals During the Nineteenth Century. M.A. Thesis, Department of Sociology and Anthropology: Carleton University.
- Fenwick, Ethel G.
1908 "Correspondence." The Canadian Nurse 4 (6):290.
- Flaw, Elizabeth G.
1919 "Letters to the Editor." The Canadian Nurse 15 (6):1806-7.

Firestone, O.J.

- 1960 "Development of Canada's Economy, 1850-1900." in Trends in the American Economy in the Nineteenth Century National Bureau of Economic Research, Studies in Income and Wealth, Volume 24, Princeton: Princeton University Press.

Fogarty, Mary H.

- 1909 "Unison in Nursing Organizations." The Canadian Nurse, 5(1):50.

Freidson, E.

- 1970 Profession of Medicine. New York: Dodds Mead and Co.

Gaffield, Chad

- 1984 "Wage Labour, Industrialization, and the Origins of the Modern Family." in The Family: Changing Trends in Canada, Maureen Baker (ed.), Toronto: McGraw-Hill Ryerson.

- 1982 "Schooling, the Economy, and Rural School in Nineteenth-Century Ontario." in Childhood and Family in Canadian History, Joy Parr (eds.), Toronto: McClelland and Stewart.

- 1978 "Dependency and Adolescence on the Canadian Frontier: Orillia, Ontario in the Mid-Nineteenth Century." History of Education Quarterly (Spring):35-47.

Gagan, David

- 1981 Hopeful Travellers: Families, Land and Social Change in Mid-Victorian Peel County, Canada West. Toronto: University of Toronto Press.

Gannage, Charlene

- 1986 Double Day, Double Bind. Toronto: The Women's Press.

Gibbon, J.M., Mathewson, M.S.

- 1947 Three Centuries of Canadian Nursing. Toronto: MacMillan.

Gidney, R.D., Millar, W.P.J.

- 1984 "The Origins of Organized Medicine in Ontario, 1850-1869." in Health, Disease and Medicine: Essays in Canadian History, Charles G. Roland (ed.), Hamilton: The Hannah Institute for the History in Medicine.

Glazebrook, G.P. deT.

1968 Life in Ontario: A Social History. Toronto:
University of Toronto Press.

Godfrey, C.M.

1979 Medicine for Ontario: A History. Belleville,
Ontario: Mika Publishing Company.

Graham, H.

1983 "Caring: A Labour of Love." in A Labour of Love:
Women, Work and Caring. London: Routledge Kegan
Paul.

Greene, Clara

1908 "Canadian Training Schools for Nurses." Presented
at Second Annual Convention of the Canadian
Society of Superintendents of Training Schools for
Nurses, October 9, Ottawa, Ontario.

Greenham, Enid

1923 "Essays on Nursing Ethics." *The Canadian Nurse*
19(5):90.

Groves, A.

1907 "Address." *The Canadian Nurse* 3(11):590-1.

Guelph General Hospital

n.d. "Golden Jubilee: School for Nurses, 1888-1938."
Guelph, Ontario: Guelph General Hospital.

Guest, Robert H.

1972 "The Role of the Doctor in Institutional
Managment." in Organization Research on Health
Institutions, Basil S. Georgopoulos (ed.), Ann
Arbor, Michigan: The Institute for Social
Research, University of Michigan.

Gunn, Jean

1918 "President's Address." Canadian National
Association of Trained Nurses, Toronto.

Habermas, Jurgen

1970 Toward a Rational Society: Student Protest,
Science and Politics. Boston: Beacon Press.

Hall, Christina McKenzie

1907 "The Small Hospital and the Training of Nurses."
The Canadian Nurse, 3(12):639-40.

Halpenny, Jasper

- 1919 "The Contribution of the Hospital to the Surgery of To-Day." Canadian Medical Association Journal 9(8):680-93.

Hamowy, Ronald

- 1984 Canadian Medicine: A Study in Restricted Entry.
British Columbia: The Fraser Institute.

Hampton-Robb, Isabel

- 1905 "The Nurse and the Public." The Canadian Nurse, 1(1):9-11.

Harris, Robin S.

- 1976 A History of Higher Education in Canada, 1663-1960. Toronto: University of Toronto Press.

Hartmann, Heidi

- 1979 "Capitalism, Patriarchy and Job Segregation by Sex." in Capitalist Patriarchy and the Case for Socialist Feminism, Zillah R. Eisenstein (ed.), New York: Monthly Review Press.

Haywood, A. K.

- 1922 "Hospital Administration as it Affects the Training School, or as It is Affected by the Training School." The Canadian Nurse 18(2):71-6.

Heffernan, Marie

- 1935 "A Short History of the Oshawa General Hospital." Oshawa, Ontario: Oshawa General Hospital.

Heney, F.A.

- 1943 "History of the Protestant Children's Hospital." Presented to the Women's Auxiliary of the Ottawa Protestant Children's Hospital, March, Ottawa.

Heron, Craig and Storey, Robert

- 1986 "On the Job in Canada." in On the Job: Confronting the Labour Process in Canada, Craig Heron and Robert Storey (eds.), Kingston: McGill-Queen's University Press.

Herrington, W.S.

- 1915 Pioneer Life Among the Loyalists of Upper Canada. Toronto: Macmillan Company of Canada, Limited.

History of Nursing Society, The

- n.d. "Pioneers of Nursing in Canada." Montreal: School for Graduate Nurses, McGill University.

- Hodgins, The Honorable Mr. Justice
1918 Report and Supporting Statements on Medical Education in Ontario. Toronto: The Legislative Assembly of Ontario.
- Hodgson, G.A.
1908 "The Nurse - I." *The Canadian Nurse* 4(2):59-60.
- Hofstadter, Richard
1955 Social Darwinism in American Thought. Revised Edition, Boston: Beacon Press.
- Hospitals Division of the Department of Health, The
1934 The Hospitals of Ontario: A Short History. Toronto: Herbert H. Ball.
- Hunter, John
1905 "The Nurse; Her Place and Her Equipment." *The Canada Lancet* 38(12):181-4.
- Hutchison, A.E.
1906 "The Mack Training School for Nurses." *The Canadian Nurse*, 11(2):18-19.
- Ink, Katherine
1919 "The Teaching Problem in the Small School." *The Canadian Nurse* 15(2).
- Jaggard, Alison
1983 Feminist Politics and Human Nature. Sussex: Rowman and Allenheld.
- John H. Stratford Hospital
n.d. "Rules and Regulations of the Training School for Nurses of the John H. Stratford Hospital." Brantford, Ontario: Expositor Print.
- Johnson, Leo A.
1974 "The Political Economy of Ontario Women in the Nineteenth Century," in Women at Work, Ontario 1850-1930. Janice Acton, Penny Goldsmith, Bonnie Shepard(eds.), Toronto: Women's Educational Press.
- Johnson, Robert E.
1982 "The Origins of Industrial Homework." in The Seam Allowance: Industrial Home Sewing in Canada, Laura C. Johnson, Toronto: Women's Educational Press.

Katz, Michael

- 1975 The People of Hamilton, Canada West: Family and Class in a Mid-Nineteenth-Century City. Cambridge, Massachusetts: Harvard University Press.

Katz, Michael B., and Davey, Ian E.

- 1978 "Youth and Early Industrialization in a Canadian City." in Turning Points: Historical and Sociological Essays on the Family, John Demos and Sarane Spence Boocock (eds.), Chicago: University of Chicago Press.

Katz, Michael B., Doucet, Michael J., Stern, Mark J.

- 1982 The Social Organization of Early Industrial Capitalism. Cambridge, Massachusetts: Harvard University Press.

King, M. Kathleen

- 1970 "The Development of University Nursing Education." in Nursing Education in a Changing Society, Mary Q. Innis (ed.), Toronto: University of Toronto Press.

Knisley, J.M.

- 1926 "Summary of the History of the Graduate Nurses' Association of Ontario, 1904-1925." Presented at the First Annual Meeting of the Registered Nurses Association of Ontario, Belleville, Ontario, April 8, 1926.

Kuhn, Annette

- 1978 "Structures of Patriarchy and Capital in the Family." in Feminism and Materialism: Women and Modes of Production, Annette Kuhn and AnnMarie Wolpe (eds.), London: Routledge and Kegan Paul.

Larrain, J.

- 1979 The Concept of Ideology. London: Hutchinson University Library.

Larson, M.

- 1977 The Rise of Professionalism. Berkeley: University of California Press.

Lawrence, Margaret Isabel (ed.)

- n.d. "History: The School for Nurses, Toronto General Hospital."

Leslie, Genevieve

- 1974 "Domestic Service in Canada, 1880-1920." in Women at Work: Ontario, 1850-1930, in Janice Acton, Bonnie Shepherd, Penny Goldsmith (eds.), Toronto: Canadian Women's Educational Press.

L'Esperance, Jeanne

- 1983 The Widening Sphere: Women in Canada, 1870-1940. Ottawa: Minister of Supply and Services.

Levere, Trevor H., Jarrell, Richard A.

- 1974 A Curious Field-Book: Science and Society in Canadian History. Toronto: Oxford University Press.

Light, Beth and Prentice, Alison

- 1980 Pioneer and Gentlewomen of British North America, 1713-1867. Toronto: New Hogtown Press.

Lowe, Graham S.

- 1986 "Women, Work and the Office: The Feminization of Clerical Occupations in Canada, 1901-1931." in Rethinking Canada: The Promise of Women's History, Veronica Strong-Boag, Anita Clair Fellman (eds.), Toronto: Copp Clark Pitman Ltd.

- 1982 "Class, Job and Gender in the Canadian Office." Labour 10 (Autumn):11-37.

Lynaugh, John., Reverby, Susan

- 1987 "Thoughts on the Nature of History." Nursing Research 36 (1):4, 69.

Macbeth, Madge

- 1959 The Lady Stanley Institute for Trained Nurses. Ottawa: Lady Stanley Institute Alumnae Association.

- 1953a "Over My Shoulder: Early Ottawa Nostalgic Memories." The Evening Citizen, Ottawa, October 31.

- 1953b "Over My Shoulder: St. Luke's Was a 'Family Hospital'." The Evening Citizen, Ottawa, November 7.

- 1953c "Over My Shoulder: Called Their Hospital Unique." The Evening Citizen, Ottawa, November 14.

MacDermot, H.E.

- 1940 History of the School of Nursing of the Montreal General Hospital. Montreal: Alumnae Association.

MacDonald, G.

- 1969 Development of Standards and Accreditation in Collegiate Nursing Education. Teacher's College Press: Columbia University, New York.

MacEachern, Malcolm T.

- 1922 "Some Hospitalization Problems-Hospital Standardization." Canadian Medical Association Journal 12(8):520-6.

Mack Training School for Nurses, The

- n.d. "The Mack Training School for Nurses, 75th. Anniversary. 1874-1949." St. Catharines General Hospital: St. Catharines, Ontario.

MacKenzie, Miss

- 1910 "The Trained Nurse Through a Business Lens." The Canadian Nurse, 6(7):289-90.

MacNab, Elizabeth

- 1970 A Legal History of the Health Professions in Ontario. A Report for the Ontario Committee on the Healing Arts, Toronto: Queen's Printer.

MacPhail, Andrew (ed.)

- 1918 "Editorial: The Nursing Crisis." The Canadian Medical Association Journal 8(9):842-3.
- 1914 "Editorial: The Hospital and War." The Canadian Medical Association Journal 4(10):906-7.

Mandell, Nancy P.

- 1974 Social Change and the Medical Profession: Whither the Professional Role? M.A. Thesis, Department of Sociology and Anthropology, Ottawa: Carleton University.

Marks, Lynne and Gaffield, Chad

- 1985 "Women at Queen's University, 1895-1905: A 'Little Sphere' All Their Own?" Historical Papers (1985):112-23.

Marx, Karl

- 1954 Capital, Volume I. Moscow: Progress Publishers.

Marx, Karl and Engels, Friedrich

- 1947 The German Ideology. New York: International Publishers.

Mathieson, K.

- 1906 "Ontario Graduate Nurses' Association, Annual Meeting." The Canadian Nurse 2(2):27-31.

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MicroD

- McCalla, Douglas and George, Peter
1986 "Measurement, Myth and Reality: Reflections on the Economic History of Nineteenth Century Ontario." Journal of Canadian Studies, 21(3):71-86.
- McDonough, Roisin and Harrison, Rachel
1978 "Patriarchy and Relation of Production." in Feminism and Materialism, Annette Kuhn and AnnMarie Wolpe (eds.), London: Routledge and Kegan Paul.
- McDougall, Duncan
1960 "Comment." in Trend in the American Economy in the Nineteenth Century, National Bureau of Economic Research, Studies in Income and Wealth, Volume 24, Princeton: Princeton University Press.
- McLeod, Maude
1919 "The University and the Training School for Nurses, Vancouver General Hospital." The Canadian Nurse 15(11):2100-3.
- McNeill, Janet G.
1910 "On Nurses and Nursing." The Canadian Nurse 6(3):109-12.
- McNichol, Vera Ernst
1971 Smiling Through the Tears. Volume II, Bridgeport, Ontario: Union Print.
- Meilicke, Carl A. and Storch, Janet L.
1980 "Introduction: An Historical Framework." in Perspectives on Canadian Health and Social Services Policy: History and Changing Trends, Carl A. Meilicke, Janet L. Storch (eds.), Ann Arbor, Michigan: Health Administration Press.
- Melosh, Barbara
1982 'The Physician's Hand': Work Culture and Conflict in American Nursing. Philadelphia: Temple University Press.
- Millman, Mary B.
1969 "Nursing in Canada." in Jensen's History and Trends of Professional Nursing, Gerald Joseph Griffin and Joanne King Griffin (eds.), St. Louis: The C.V. Mosby Company.

- Mitchinson, Wendy
 1984 "Causes of Diseases in Women: The Case of Late 19th Century English Canada." in Health Disease and Medicine: Essays in Canadian History, Charles G. Roland (ed.), Hamilton: The Hannah Institute for the History of Medicine.
- Mohun, Simon
 1983 "Labour Process." in A Dictionary of Marxist Thought, Tom Bottomore (ed.), Cambridge, Massachusetts: Harvard University Press.
- Morgan, David H.J. and Taylorson, Daphne E.
 1983 "Introduction: Class and Work: Bringing Woman Back In." in Gender, Class and Work, Eva Gamarnikow, David H.J. Morgan, June Purvis, Daphne E. Taylorson (eds.), London: Heinemann Educational Books.
- Morgan, Henry James
 1912 The Canadian Men and Women of the Time: A Hand Book of Canadian Biography of Living Characters. Toronto: William Briggs.
- Morley, Mrs.
 1949 "History of The Mack Training School for Nurses." St. Catharines, Ontario: St. Catharines General Hospital.
- Morrison, T.R.
 1976 "'Their Proper Sphere' Feminism, The Family and Child-Centered Social Reform in Ontario, 1875-1900. Part I." Ontario History, LVXIII(1):45-64.
- Morrison, W.R.
 1976 "'Their Proper Sphere' Feminism, The Family and Child-Centered Social Reform in Ontario, 1875-1900. Part II." Ontario History, LVXYII(1):65-74.
- Moscovitch, Allan
 1983 The Welfare State in Canada: A Selected Bibliography, 1840-1978. Waterloo, Ontario: Wilfred Laurier University Press.
- Mullin, J.H., Routley, T.C.
 1921 "Medical Legislation." Canadian Medical Association Journal 11(4):298-304.
- Nett, Emily
 1981 "Canadian Families in Social-Historical Perspective." Canadian Journal of Sociology 6(3):239-60.

Noble, David F.

- 1978 "Social Choice and Machine Design: The Case of Automatically Controlled Machine Tools, and a Challenge for Labor." *Politics and Society* 8(3-4):313-47.

Nutting, M.A.

- 1908 "Some Problems of the Training School." *The Canadian Nurse*, 4(12):582-96.

Ogden, V. (ed.)

- 1879 "Training School for Nurses, Toronto General Hospital." *Canadian Journal of Medical Science* 4(March):94-5.

Omvedt, Gail

- 1986 "'Patriarchy': The Analysis of Women's Oppression." *The Insurgent Sociologist*, 13(3):30-50.

Ontario Hospital Association

- 1902 "Proceedings of the Ontario Hospital Association." *The Canadian Practitioner* 27(March):149-52.

Paffard, Agnes McIntyre

- 1913 "History of the Graduate Nurses' Association of Ontario." *The Canadian Nurse*, 9(5):296-303.

Paul-Emile, Sister

- n.d. "Ottawa General Hospital, 1845-1980." Ottawa.

Pentland, H.C.

- 1959 "The Development of a Capitalistic Labour Market in Canada." *Canadian Journal of Economics and Political Science*, XXV(February-November):450-61.

Phillips, Anne and Taylor, Barbara

- 1980 "Sex and Skill: Notes Towards a Feminist Economics." *Feminist Review*, 6:79-88.

Phillips, Paul and Phillips Erin

- 1983 Women and Work: Inequality in the Labour Market. Toronto: James Lorimer and Company, Publishers.

Pollert, Anna

- 1983 "Women, Gender Relations and Wage Labour." in Gender, Class and Work, Eva Gamarnikow, David H. J. Morgan, June Purvis, Daphne E. Taylorson (eds.), London: Heinemann Educational Books.

"Practitioner"

- 1908 "The Hospitals." *The Canadian Practitioner*
33 (February):134-5.

Prentice, Alison

- 1975 "The Feminization of Teaching in British North America and Canada, 1845-1875." *Social History*
8 (15):5-20.

Pringle, Ina F.

- 1915 "Report of the Recording Secretary." Twelfth Annual Meeting of the Graduate Nurses' Association of Ontario, May 22, Toronto, Ontario.

Ramkhalwansingh, Ceta

- 1974 "Women During the Great War." in Women at Work: Ontario, 1850-1930, Janice Acton, Bonnie Shepherd, Penny Goldsmith (eds.), Toronto: The Canadian Women's Educational Press.

Registered Nurses' Association of Ontario

- 1963 "Interpretive Information in Respect to the History, Organization and Activities of the RNAO." Toronto: Registered Nurses' Association of Ontario.

Reverby, Susan Mokotoff

- 1982 The Nursing Disorder: A Critical History of the Hospital-Nursing Relationship, 1860-1945. Ph.D. Thesis, Boston, Massachusetts: Boston University Graduate School.

Richards, Linda S.

- 1908 "The Return of the Two Year Course. Is it a Necessity? If so, Why?" *The Canadian Nurse*, 4 (10):463-4.

Riddell, Dorothy G.

- 1970 "Nursing and the Law: The History of Legislation in Ontario." in Nursing Education in a Changing Society, Mary Q. Innis (ed.). Toronto: University of Toronto Press.

Riggs, Dr. H.W.

- 1916 "The Doctor as a Factor in the Education of a Nurse." *The Canadian Nurse*, 12 (10):559-60.

Robb, Isabel-Hampton

- 1906 Nursing: Its Principles and Practice. Toronto: J.A. Carveth and Company (Ltd.).

Roberts, Sir Charles G.D., Tunnell, Arthur Leonard
 1936 The Canadian Who's Who. Toronto: Arthur Leonard Tunnell.

Robertson, J. Ross
 1908 "A Layman's View of Hospital Work." *The Canadian Nurse*, 4(10):545-56.

Rogers, Miss
 1910 "The Hospital: From the Superintendent of Nurses' Point of View." Fourth Annual Meeting of the Canadian Society of Superintendents of Training Schools for Nurses, May 25, Toronto, Ontario.

Roland, Charles G.
 1980 "Ontario Medical Periodicals as Mirrors of Change." *Ontario History* 77(1):3-15.

Ross, Carolyn
 1910 "The Hospital: From a Graduate's Point of View." Fourth Annual Meeting of the Canadian Society of Superintendents of Training Schools, May 25, 1910, Toronto.

Rubin, Lillian Breslow
 1976 Worlds of Pain. New York: Basic Books, Inc., Publishers.

Runnalls, John Lawrence
 1974 A Century with the St. Catherines General Hospital. St. Catherines, Ontario: St. Catharines General Hospital.

Russell, E. Kathleen
 1958 "Changes in the Patterns of Nursing." *The Canadian Nurse* 54(6):529-32.

1951 "Medicine as a Social Instrument: Nursing." *New England Journal of Medicine* 244(March 22):439-45.

St. Joseph's General Hospital
 1958/ "St. Joseph's General Hospital." Port Arthur,
 1959 Ontario.

St. Joseph's School of Nursing
 n.d. "St. Joseph's School of Nursing, 1912-1974." Kingston, Ontario.

Saunders, Eileen
 1983 Women, the Economy and the Socialist State: The Case of China. Ph.D. Thesis, Ottawa: Department of Sociology and Anthropology, Carleton University.

Scott, Jean Thomson

- 1892 "The Conditions of Female Labour in Ontario."
Toronto: Toronto University Studies in Political
Science.

Sedgewick, Reverend Robert

- 1976 "The Proper Sphere and Influence of Woman in
Christian Society." in The Proper Sphere, Ramsay
Cook and Wendy Mitchinson (eds.), Toronto: Oxford
University Press.

Seecombe, Wally

- 1980 "Domestic Labour and the Working Class Household."
in Hidden in the Household: Women's Domestic
Labour Under Capitalism, Bonnie Fox (ed.),
Toronto: The Women's Press.

Shepherd, Dr. Francis J.

- 1906 "Montreal General Hospital - A Short Historical
Retrospective." *The Canadian Nurse*, 11(1):17-25.

Shortt, S.E.D.

- 1983-1984 "The Canadian Hospital in the Nineteenth
Century: An Historiographic Lament." *Journal of
Canadian Studies* 18(4):3-14.

Sinclair, Bruce., Ball, Norman R., Petersen, James O.

- 1974 Let Us be Honest and Modest: Technology and
Society in Canadian History. Toronto: Oxford
University Press.

Smith, R.W. Bruce

- 1907 "The Responsibilities of Hospital Superintendents."
The Canada Lancet 40(9):774-9.

Snively, Mary Agnes

- 1905a "The Toronto General Hospital Training School for
Nurses." *The Canadian Nurse*, 1(1):7-9.

- 1905b "The Toronto General Hospital Training School for
Nurses." *The Canadian Nurse* 1(2):21-4.

Special Committee on Nurse Education

- 1914 "Report of the Special Committee on Nurse
Education." *The Canadian Nurse* 10(10):570-85.

Spelt, Jacob

- 1972 Urban Development in South-Central Ontario.
Toronto: McClelland and Stewart Limited.

Splane, Richard B.

1965 Social Welfare in Ontario: 1791-1893: A Study of Public Welfare Administration. Toronto: University of Toronto Press.

Stanley, Margaret E.

1908 "Preliminary Training." *The Canadian Nurse* 4 (11):535-6.

Steedman, Mercedes

1986 "Skill and Gender in the Canadian Clothing Industry, 1890-1940." in On the Job: Confronting the Labour Process in Canada, Craig Heron and Robert Storey (eds.), Kingston: McGill-Queen's University Press.

Stewart, Isabel M.

1912 "The Place of Apprenticeship in Vocational Education." *The Canadian Nurse*, 8 (1):14-8, 8 (2):65-8, 8 (3):124-7.

1912b "Newer Branches of Nursing." *The Canadian Nurse* 8 (7):393-401.

Street, Margaret M.

1974 "Canadian Nursing in Perspective: Past, Present and Future." Keynote Address, Fiftieth Anniversary of the University of Alberta Hospital and the University of Alberta Schools of Nursing, November 15, University of Alberta: Edmonton.

1973 Watch-fires on the Mountains: the life and writings of Ethel Johns. Toronto: University of Toronto Press.

Stretton, Eva

1915 "Preliminary Training." *The Canadian Nurse* 11 (4):194-6.

Strong-Boag, Veronica

1986 "Keeping House in God's Country: Canadian Women at Work in the Home." in On the Job: Confronting the Labour Process in Canada, Craig Heron and Robert Storey (eds.), Kingston: McGill-Queen's University Press.

1979 "Feminism Constrained" in A Not Unreasonable Claim: Women and Reform in Canada, 1880's-1920's, Linda Kealey (ed.), Toronto: The Women's Press.

Sutherland, Neil.

- 1976 Children in English-Canadian Society: Framing the Twentieth Century Consensus. Toronto: University of Toronto Press.

Thompson, J.B.

- 1983 "Ideology and the Critique of Domination." Canadian Journal of Political and Social Theory 7(1-2):163-83.

Tilly, Louis A., Scott, Joan W.

- 1978 Women, Work, and Family. New York: Holt, Rinehart and Wilson.

Torrance, George M.

- 1980 "Socio-Historical Overview." in Health and Canadian Society: Sociological Perspectives, D. Coburn, C. D'Arcy, P. New, G. Torrance (eds.), Toronto: Fitzhenry and Whiteside.

Traves, Tom

- 1983 "Security Without Regulation." in The Consolidation of Capitalism, 1896-1929, Readings in Canadian Social History, Volume 4, Michael S. Cross, Gregory S. Kealey (eds.), Toronto: McClelland and Stewart.

Trofimenkoff, Susan

- 1981 "One Hundred and Two Muffled Voices: Canada's Industrial Women in the 1880's." in Canada's Age of Industry, 1849-1896. Readings in Canadian Social History, Volume 3. Michael S. Cross and Gregory S. Kealey (eds.), Toronto: McClelland and Stewart.

Ursel, Jane

- 1986 "The State and the Maintenance of Patriarchy: A Case Study of Family, Labour and Welfare Legislation in Canada." in Family, Economy and the State: The Social Reproduction Process under Capitalism, James Dickinson, Bob Russell (eds.), Toronto: Garamond Press.

- 1984 "Toward a Theory of Reproduction." Contemporary Crises, 8(1984):265-92.

Vicinus, Martha

- 1985 Independent Women: Work and Community for Single Women, 1850-1920. Chicago: University of Chicago Press.

Vogel, Morris., Rosenberg, Charles

- 1979 The Therapeutic Revolution: Essays in the Social History of American Medicine. Philadelphia: Temple University Press.

Wallace, Elisabeth

- 1980 "The Origin of the Social Welfare State in Canada, 1867-1900." in Perspectives on Canadian Health and Social Service Policy: History and Emerging Trends, Carl A. Meilicke, Janet L. Storch (eds.), Ann Arbor, Michigan: Health Administration Press.

Wilson, S.J.

- 1982 Women, the Family and the Economy. Toronto: McGraw-Hill Ryerson.

Wilson, W.J.

- 1900 "That 'Bete Noir', Hospital Abuse." Canadian Journal of Medicine and Surgery 8(1):54-6.

Winslow, Victoria

- 1920 "Training School Requirements." The Canadian Nurse 16(2):86-9.

Wood, Stephen (ed.)

- 1982 The Degradation of Work? Skill, Deskilling and the Labour Process. London: Hutchinson.

Woodham-Smith, Cecil

- 1950 Florence Nightingale: 1820-1910. London: Constable.

Worcester, Alfred

- 1923 "Special Training in Home Nursing." The Canada Lancet and National Hygiene 61(1):19-25.

Wright, A.H. and Cameron, I.H. (eds.)

- 1881 "Clinics in the Toronto General Hospital." Canadian Journal of Medical Science 6(November):362-3.

- 1882a "Consultation with Homeopaths." Canadian Journal of Medical Science 7(February):61-2.

- 1882b "Directory for Nurses." Canadian Journal of Medical Science 7(December):399-400.

Young, Iris

- 1981 "Beyond the Unhappy Marriage: A Critique of Dual Systems Theory." in Women and Revolution, Lydia Sargent (ed.), Montreal: Black Rose Books.

Young, W.A.

1899 "Physicians and Their Relation to Charitable
Institutions." Canadian Journal of Medicine and
Surgery 5(3):196-7.

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