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1951 Agreement Between the Red Cross and St. John Ambulance: A case study of the effect of civil defence on Canada's Health Care System

by

Deanna Toxopeus, B.A.

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

Department of History
Carleton University
Ottawa, Ontario
March 1, 1997

The undersigned recommend to the Faculty of Graduate Studies and Research acceptance of the thesis

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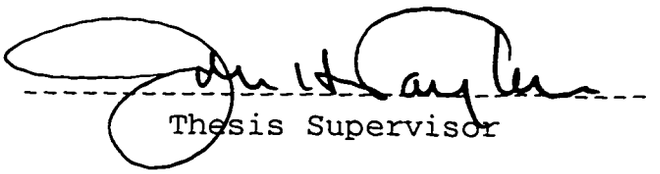

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21 May 1997

Abstract

Until 1951 St. John Ambulance and the Red Cross were traditional rivals in Canada, but in that year the two organizations signed an agreement rationalizing their roles in the Canadian Health and Welfare State of the post-war period. Each organization gave up part of its operations in order to achieve this agreement. The Red Cross traded the right to run first aid courses in favour of exclusive rights to type, collect and distribute blood (and eventually blood products) in Canada. St. John Ambulance ceased to operate its blood grouping clinics in exchange for assurances that the Red Cross would stay out of the field of industrial first aid.

The broker of this agreement was the Federal Government. Ottawa was concerned with introducing the Canadian population to the medical miracle of blood transfusion. It also wanted a rationalized first aid training system. Additionally, the Federal Government wanted to do both things with little cost and without stepping on provincial toes. The facilitating opportunity was provided by the Cold War and the needs of Civil Defence.

In some measure, this intervention into a major health area can be seen as a happy accident. To paraphrase Armstrong and Nelles, determinism is more evident in hindsight. The 1951 agreement occurred in a set of circumstances that allowed all three parties to view as valuable the concessions necessary to achieve the agreement.

Acknowledgements

This thesis would not have been possible without the help and support of a lot of people. Of course any mistakes in this thesis are mine and mine alone. Among those I have to thank are:

My mother, Linda Fielding, for the food, the laundry facilities, and just being there for me.

My father, Rieks Toxopeus, for all of his advice, whether asked for or not.

The rest of my family for their love and support.

Anne Boutrin, the tireless archivist and librarian at the Canadian Red Cross Headquarters for all her help and direction.

Joan Wills and Ruth Vant at the St. John Ambulance National Headquarters for accommodating and helping with my requests.

The staff at the National Archives, a resource and a treasure.

Professors Scanlon, Hillmer and Marshall who took the time to talk to me at the beginning of my research.

My boss, Pat Finn, for the use of the computer and the understanding when I needed some time off.

Bev and Jim, surrogate parents in every way.

The Fleet, RBLS, EKES, the Gazette Staff, the Feller Few, Brick, Steven and all my other net friends for understanding when I just couldn't talk, and listening when I needed it.

Mummy, Mike, James, Wendy, Laurie, Bob, Mimi, Cherie, Mark, Pam, Nancy, Cheryl, Gilles, Sheila, and the House of Skylark for being **true** friends by not asking me how the thesis was going.

Dave and Sue for giving me a gift whose value grows with every day.

Margaret-Anne for her amazing command of the English language, not to mention being the best friend a person could ask for.

Rick for challenging me, pushing me, believing in me and cherishing me for who I am, warts and all, and for not letting me use him as an excuse not to work on the thesis.

And finally, John Taylor. Without his help and guidance, I would never have been able to finish this. John knew when to push, when to coddle and when to let me stew. From him I have learned a great deal about writing, scholarship, teaching and myself. Thank you, John.

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Chapter 1 - Introduction

On January 26, 1951, the Red Cross and St. John Ambulance met at Rideau Hall in Ottawa in order to sign a government-sponsored agreement that would rationalize their respective activities in post-World War II Canada, and specifically, that would rationalize the sections of Canadian health care that would be the responsibility of each organization. The signing ceremony was the culmination of two years of negotiations between St. John Ambulance and the Red Cross, negotiations that had been suggested by the Federal Government.

Prior to this agreement, the two groups both taught first aid and home nursing to the public. Both were also involved in the collecting and typing of blood, although St. John Ambulance chiefly for the war effort and for Civil Defence purposes. From 1951 onward the Red Cross became solely responsible for the collection of blood in Canada. St. John Ambulance, in turn, was granted the responsibility for teaching first aid to the Canadian public. The responsibility for the teaching of home nursing (in which both organizations were engaged) was not covered in this agreement, and was to be negotiated at a later date. The agreement would be renewed each year, with both organizations having the option not to sign the renewal. The rationale given for this agreement was the improvement in the efficiency of Canada's Civil Defence system, an efficiency that was seen as imperative in the face of the dangers posed by the advent of the Cold War.[1]

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[1] *Canadian First Aid*, Vol. 6, No. 3, March 1915, pp. 5 & 29; Margaret MacLaren. *Summary of the 1951 St. John Ambulance - Red Cross Agreement* dated October 20, 1961, St. John Ambulance National Headquarters.

Prior to 1951, both groups competed against each other for funds and were reluctant partners at the best of times. Yet the Canadian government was able to facilitate an amicable agreement between the two organizations that would last for nearly a quarter of a century. Both St. John Ambulance and the Red Cross continued to abide by the terms of the agreement until 1973, with little or no further intervention by the government.[2] A second issue is how the federal government chose to deal with the advent of a new technology: in this case, blood transfusion. In this matter the Canadian government, to serve the public interest, negotiated a voluntary-sector monopoly with joint federal-provincial oversight, opting neither for regulation of the private sector nor for public takeover. In the US, by contrast, the blood system was, for a time, a mish-mash of public and private, "for-profit" and "not-for profit" agencies. In Europe the norm became a blood system run by the government. In Canada, the federal government seems to have opted for a variation on one of the often-used Canadian answers to the problem of who administers such new technologies as blood transfusion: monopolies with government regulation.[3] A third issue, and the most theoretically controversial, raised by this agreement is that of the relationship between the state and the voluntary sector on matters of health and social welfare. Was there a normative relationship? Or was it contingent? And flowing from these questions, what accounts for it?

In exploring this issue, James Struthers, in his introduction to *The Limits of Affluence:*

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[2] In early 1973 the Red Cross informed St. John Ambulance that they were not interested in renewing the agreement. From that point on, both organizations were involved in direct competition in the first aid field. - Interview Toby Spry - January 26, 1994.

[3] Christopher Armstrong & H.V. Nelles. *Monopoly's Moment: The Organization and Regulation of Canadian Utilities, 1830 - 1930*, (Toronto: University of Toronto Press), 1986, pp. 3-5.

Welfare in Ontario, 1920-1970 identifies what he calls "at least six distinct interpretations of the origins and development of welfare state policies."[4] Careful reading of his analysis in fact reveals seven interpretations, with the seventh having two sub-groupings.

When historians first began looking at the evolution of social programs, the histories tended to be hagiographic in nature. Social security programs were the result of the efforts of "enlightened and altruistic reformers".[5] The problem with the hagiographic approach is that there is very little critical analysis and objectivity. This is particularly true of the official histories that many institutions produced as commemorations of anniversaries and the like. These histories were generally written for a fee by the author, who was often a long-time member or supporter of the organization. This is certainly true with works such as *To All Men* and *The White Cross in Canada*, the official histories of the Canadian Red Cross and St. John Ambulance respectively. In the minds of these types of organizations the purpose of official histories is "recording their (often impressive) achievements".[6] While this approach is not one generally adopted by academic historians, quite often these works are the only public source of information on benevolent organizations.

The next type of historical inquiry into the evolution of social programs emerged in the late 1950s, and for Struthers this was the first interpretative effort. Most closely associated with the work of Harold and Wilensky, this analysis of the development of social welfare has

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[4] James Struthers. *The Limits of Affluence: Welfare in Ontario, 1920-1970*, (Toronto: University of Toronto Press), 1994, p.5.

[5] Struthers, p. 6.

[6] John F. Hutchinson. *Champions of Charity: War and the Rise of the Red Cross*, (Boulder, Colorado: Westview Press), 1996, p. xiii.

been described as the "logic of industrialism school."[7] Welfare programs were seen as "a logical and inevitable response to the forces of industrialism, urbanization and the expansion of a wage-earning labour force."[8]

The arguments of Wilensky and his colleagues are persuasive when examining the "highwater mark of the Keynesian welfare state"[9], a period Struthers identifies as 1945 to 1970, but, in and out of the period, problems still exist with these theories. Wilensky's theories do not explain why the order of emergence of social policies varied from country to country, or even why some or all of those policies never emerged at all. The question of timing also comes up. If industrialism is the main cause of social development, why did countries such as Australia and New Zealand experiment with old age pensions long before more industrially-advanced countries such as the US? Wilensky's hypotheses are also not helpful in explaining why the attempts of groups to implement new initiatives might fail in one country, while succeeding in a neighbouring nation.[10]

At the same time that Wilensky and his peers were advocating the logic of industrialism, a group of political-cultural theorists were advocating the influence of a nation's political culture on the evolution of social programs. Led by Seymour Martin Lipset, Louis Hartz and Gaston Rimlinger, this group was originally interested in explaining why the US had opted for an individualist and residualist approach to welfare, especially in comparison to the

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[7] Struthers, pp. 5-6.

[8] Struthers, p. 6

[9] Struthers, p. 6.

[10] Struthers, pp. 4-7.

more comprehensive state programs of Europe and even Canada. These scholars believed that the differences in various nations' social programs were a result of the differences in each country's shared values and beliefs.

The Canada variation on this theory found its voice in scholars such as John Wilson, S.F. Wise, H.V. Nelles and S.J.R. Noel. These scholars attributed the development of Canada's social security system to a tradition of leadership by the elite and a trust in the state. This tradition was also used to explain the tendency for one party to dominate in provincial politics and the willingness of the public to look to the government for help in times of trouble. But the political culture theory runs into trouble in linking widely-held values to specific policies and initiatives. For example, why public education was an early and widespread initiative in North America, but not in Europe. Political culture theory also does not explain clearly the change in initiatives or values over time, nor does it address the issue of class, ethnic and gender inequalities in social policy initiatives. In other words, it is not clear whose values are determining the social policy, and how widely they are held.[11]

Social Democratic is the label Struthers applies to the fourth school of thought about the evolution of social security programs. It argues that the modern welfare state reflects the influence of the labour movement in a civil society. Social security is seen as consisting of whatever benefits labour has been able to wrest from a fiercely resisting capitalist economy and its state.

This school is quite successful in explaining the timing of specific social policy

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[11] Struthers, pp. 7-8.

initiatives, and at understanding the achievement or reversal of a certain policy. Social democracy also helps to explain the conflict inherent achieving these policies, as well as acknowledging the importance of agency, ideology and class mobilization in achieving social policy initiatives. As yet, no one has used this approach exclusively with the Canadian situation.[12]

At about the same time as social democracy arose, another labour-oriented interpretation was coming to the fore. Marxism or neo-Marxism, unlike social democracy, sees social security as an instrument of state control. The welfare state is created both to control market forces such as inflation, which could hurt capital, and at the same time to ensure a large source of cheap and ready labour by having the state absorb the cost of benefits and income security. For the Canadian situation, then, Marxists and neo-Marxists are not able to fully explore the role of regionalism, working-class agency, and professional ideology in the development of social policy.[13]

More recently, perhaps as a reaction to the previous two schools of thought, some scholars have advanced the idea of the state as an independent actor in shaping the development of social security. This school has been given a variety of names: New Institutionalism, Bureaucratic Autonomy, or Structured Polity Perspective. Hugh Heclo and Theda Skocpol are two of its better known advocates. Its state-centred approach is different from the previous schools of thought in that it does not see the state as a passive agent of societal forces. Government officials, according to these scholars, are leaders of social

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[12] Struthers, pp. 8-10.

[13] Struthers, pp. 10-12.

change. They developed welfare by examining the results of previous policy in terms of an on-going dialogue with policy professionals and advocacy groups outside of government. To this dialogue they brought their experience gained through careers in both government and government agencies. This interpretation, then, sees civil servants and politicians as active agents working for social change.

This state-centred approach helps to explain why different nations developed social security programs at different rates, if they were developed at all. It also takes into account the unintended effects of various initiatives, the impact of feedback from previous legislation and the importance of incremental change. For these reasons, the state-centred method is excellent for studying the change and development that occurs in social welfare programs over time. This interpretation also acknowledges a historical role for members of the knowledge-based professions (such as social workers) by examining and explaining their place within, and their links to, the government. State interventionism also acknowledges the importance of jurisdictional rivalry within and between various levels of government, making it particularly useful when studying the Canadian context.

The problem with state interventionism is that it tends to overstate the role of the state, the officials and politicians within it. In doing so, this approach understates the importance of shared culture, background and perspective of the managers in government and the managers in business. For example, the state-centred approach does not explain why between 1920 and 1970 promotions in the Ontario Department of Public Welfare were based primarily on book-

keeping and accounting skills, not on any expertise or experience in social work.[14] It also ignores the role of marginalised groups in society, including women, racial and ethnic minorities in effecting change in social welfare policies. There is also a tendency with the state-centred approach to sanctify the intentions and actions of the officials and politicians involved, in a way reminiscent of the earlier hagiographic approach. As history has shown many times, not all government officials have altruistic motives.[15]

The most recent school of thought regarding the development of social security is that of gender. Feminist scholars began to question the lack of women in the history of social welfare, and in so doing have sought to explain the development of social programs from a women's point of view. Struthers admits that there is really no one dominating theory among these scholars, but, in the process of analysing their scholarship, he does identify two divergent trends.

The first sub-grouping is made up of scholars who see social welfare as a means of controlling and repressing women. For this group of scholars, women are seen by the state as being dependents of male workers. Welfare policies then are constructed by the state to uphold this belief, excluding women from the labour market and upholding their roles as mothers and caretakers of the nation's children. Even when women were supported by the state, it was only in their guise as mothers. These programs were administered as charities, unlike the programs for male wage earners which were seen as citizenship or entitlement rights. These types of welfare programs, scholars argue, also led to the moral regulation of

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[14] Struthers, p. 13.

[15] Struthers, pp. 12-14.

the female clients as every detail of their private lives was examined in order to determine eligibility for benefits. The term "malestream" was coined by T.H. Marshall to describe this welfare philosophy. Gender analysis also provides a framework with which to study the increasing feminization of poverty. Social welfare, then, is seen as an illustration of the gender inequality that existed in a society. Male dominance over women is perpetuated by the state as it increasingly becomes a substitute for absent husbands and fathers in regulating and controlling the lives of women.[16]

Perhaps in response to this approach, or perhaps growing out of it, feminist scholars developed another perspective on the history of social welfare that of women working together to effect change in policy. What these scholars argue is that social welfare programs, such as mother's allowance, were cross-class achievements of women attempting to build a "maternalistic welfare state".[17] Working-class women would influence the middle-class female reformers to implement new social initiatives. This approach allows historians to view women as political actors capable of effecting change.[18]

Struthers does not argue that anyone of these theories is more important than the other, but instead, makes his own case on the basis of historical contingency. He argues that, due to the complex and haphazard nature of the development of Canadian social welfare, all these theories apply to varying degrees. The same can be said about the 1951 agreement between the Red Cross and St. John Ambulance..

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[16] Struthers, pp. 14-15.

[17] Struthers, p. 15.

[18] Struthers, p. 16.

There was no one grand structural imperative that led to the agreement, nor was there one great visionary. The Canadian government did not set out to establish a blood system and deal with the rivalry between these two organizations in one fell swoop. As Armstrong and Nelles state, "[d]eterminism is more obvious in retrospect".[19] Rather, the agreement occurred in a set of circumstances that made it convenient for Ottawa to sponsor the agreement. One, the Red Cross was aware of the great benefits of blood transfusion, and wanted to continue the blood system after the war. Two, neither the federal nor provincial governments had either the money or the will to set up their own system. Three, the advent of the Cold War necessitated the streamlining of Canadian response systems, including those of emergency health care. Four, St. John Ambulance was seeing a drop in enrollment in their first aid courses, and was looking for new clients. All of these factors combined at the right time to make the agreement possible. Take away any one of them and, one can speculate, the agreement would not have been possible.

The 1951 agreement thus focuses on many aspects of state intervention, raising questions concerning its purpose, especially the complexity of its nature and its causes or the motivations of politicians and administrators. An examination of the 1951 agreement demonstrates that the emergence of the welfare state and the regulation of technical innovation was truly a mixed proposition. It was not just a mix of public and private initiatives, but a combination of public and private activities. And, beneath the mixture of activities, was a complex fusion of structural imperatives and often self-serving motives but still with a broad

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[19] Armstrong and Nelles, p. 5.

streak of altruism.

Chapter 2 - The Voluntary Sector

Both St. John Ambulance and the Red Cross in 1945 were international benevolent organizations with good reputations. Both organizations rose to prominence in Canada at the same time as many other organizations interested in social reform, such as the Women's Christian Temperance Union (WCTU) and the Social Service Council of Canada.[20] Traditionally rivals, St. John's and the Red Cross' paths converged in wartime. This may have been what led both the organizations and the federal government to believe that co-operation would be possible in the post-war period.

The Establishment of St. John Ambulance

The origins of St. John Ambulance lie in the re-establishment of the three Langues[21] of the Knights Hospitaller of Jerusalem in France after the defeat of Napoleon in 1815.[22] The goal of these three groups was to raise the Knights Hospitaller back to the level of their former prominence. One step in this plan was to re-establish the English branch of the Order. An

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[20] Allan Moscovitch & Glenn Drover. "Social Expenditures and the Welfare State: The Canadian Experience in Historical Perspective" in *The "Benevolent State": The Growth of Welfare in Canada*, Allan Moscovitch (ed), (Toronto: Garamond Press), 1987, p. 20.

[21] In the Middle Ages, the Knights Hospitallers were divided into eight divisions, based on language. There were as follows: Provence, Auvergne, France, Italy, Castille, Aragon, England and Germany. These divisions, called Langues, were quasi independent bodies that governed the monastic houses within their geographical area. The English Langue, although never abolished by Queen Elizabeth, died out quickly after her ascendence to the throne. The French Langues (Provence, Auvergne and France) where abolished by Napoleon upon his ascendence to the throne. - E.D. Renwick *The Order of St. John: A Short History*, London: St. John's Gate, 1971, p. 17.

[22] J.M. Thompson, *Napoleon Bonaparte*, New York: Oxford University Press, 1952, pp. 414-416; G.W.L. Nicholson. *The White Cross in Canada: A History of St. John Ambulance*, Montreal: Harvest House, 1967. p. 17; & Strome Galloway, *The White Cross in Canada, 1883-1983: A History of St. John Ambulance, Centennial Edition*, (Ottawa: The Priory of Canada of the Most Venerable Order of the Hospital of St. John of Jerusalem), 1983, p.17.

English committee was formed and a Prior was elected in January 1831. Unfortunately for the French and their plans, the Sovereign Order in Rome refused to admit another Protestant branch to the order (there already being one in Brandenburg). It is not clear from the sources what the French Langues did after this defeat, but the English committee decided to become an independent body.[23] The Order of St. John of Jerusalem was established in England in 1858.[24] The Order of the Knights Hospitaller themselves underwent a change in 1878, when they were converted by the Pope to a secular charitable order.[25]

When the Franco-Prussian war broke out in August of 1870, the British National Society for Aid to the Sick and Wounded in War was formed. This group was concerned primarily with providing adequate medical aid to both sides, and can be seen as a continuation of the work of Florence Nightingale in the Crimean War.[26] The group was also made up chiefly of members of the Order of St. John of Jerusalem. The Society set up a voluntary medical corps and began recruiting personnel, primarily doctors and nurses. There is no explanation provided in the sources as to whether or not the doctors and nurses who were recruited were already trained regarding combat medicine, or whether they were given additional training by the society. It is possible, considering the state of medicine in general at that time, that they were given no additional training at all. At its peak, the corps was two

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[23] Nicholson, pp. 17-18; & Galloway, p. 17.

[24] Fletcher, N. Corbet. *The St. John Ambulance Association: Its History, and its Part in the Ambulance Movement*, (London: The St. John Ambulance Association), unknown, p. 5.

[25] *The Middle Ages: A Concise Encyclopaedia*, London: Thames and Hudson, 1989, p.201.

[26] Monica E. Bayly, *Nursing and Social Change*, London: William Heinemann Medical Books, Ltd., 1980, pp.118-123; & Fletcher, p. 10.

hundred strong.[27]

This humanitarian effort eventually led to the Order of St. John and the setting up of the St. John Ambulance Association in 1877. The primary goals of this new association were twofold: "'to train men and women for benefit of sick and wounded', and to provide a 'civilian reserve for the Army Medical Department'"[28] These two goals eventually led to the establishment of the two arms of the modern St. John Ambulance. The training goal led to the modern St. John Ambulance Association, which is today responsible for teaching first aid to the public. The goal of a "civilian reserve" led to the St. John Ambulance Brigade, a group of volunteers who provided first aid services at public events. The Order of St. John received a Royal Charter in 1888.[29]

The Establishment of St. John Ambulance in Canada

St. John Ambulance made its first recorded Canadian appearance in 1883, when first aid courses were taught in Quebec City.[30] The Priory of Canada, the Canadian governing body of St. John Ambulance, has accepted this date as its founding for the Canadian Branch of the Order, even though no official section of the Priory existed at this point. The first local Canadian Association was not formed until 1892, in Nova Scotia. A national governing body was not established until 1897, when the Ontario Council was expanded and renamed the

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[27] Fletcher, p. 5.

[28] Nicholson, p. 19; & Galloway, pp. 19-20.

[29] Renwick, p.59; Fletcher, pp. 27-28.

[30] Nicholson, p. 29 and Galloway, p. 25.

Dominion Council.[31]

The former reliance on England can be seen in the events just prior to World War I [32]. After the enthusiasm of the turn of the century, the Canadian branch of St. John suffered a decline. The Priory in England, concerned that it had received no reports from its subsidiary in Canada, sent "crusades" to investigate, and, if necessary, revive interest. The second crusade in 1909 found that the Dominion Council had ceased to exist. An organizational meeting was held at Parliament Hill and was chaired by Earl Grey, the Governor General.[33] This led to a cross-country revitalization, which started in the Maritimes and crossed back and forth across the country, until there were five strong provincial councils.[34] This revitalization also led to the forming of the first Canadian Brigade unit (male). The no. 1 London (Forest Hill) Ambulance Division, was founded in London, Ontario, on May 3, 1909.[35] The first Nursing (female) Division, Toronto (Central) No. 1 Nursing Division, was established three years later.[36]

Canada did not become a priory in its own right, and therefore a self-governing organization, until 1946.[37] The distinctions are important. To be a separate priory means a

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[31] Nicholson, p. 33; & Galloway, p. 29.

[32] Heren after refered to as WWI.

[33] Nicholson, pp. 34-35; & Galloway, pp. 30-31.

[34] Nicholson, pp.37-41; & Galloway, pp. 33-48.

[35] Nicholson, p.44; & Galloway, p. 22.

[36] Galloway, p. 22; & Nicholson p. 45.

[37] Nicholson, p. 125-126; & Galloway, p. 103-104.

country has the right to make decisions independently of the British Headquarters at Clerkenwell. As a section of the British Order, the Canadian branch had to follow the dictates of the Commandary Headquarters in England. Becoming a priory in its own right meant that St. John Ambulance was able to reflect on and react to the changes in Canadian society.

St. John's Role in Civil Defence

This independence became important as St. John Ambulance began to create a role for itself in post-war Canada. At the end of WWII, *Canadian First Aid*, the St. John Ambulance magazine, began to shift its focus from St. John's efforts in the war to those on the home front. St. John Ambulance saw its role in civil defence as being both the instructor of first aid and home health care as well as the provider of trained first aid personnel in case of attack. First aid courses were advocated both in the home and in the workplace. Women were advised to take family health care courses in order to help take care of sick relatives and friends at home. Initially, St. John Ambulance used Dr. Mustard's *Fundamentals of First Aid* as the basis of its civil defence first aid courses. When that particular text proved inadequate for the Canadian situation at the dawning of the nuclear age, the training department began adding a section to the end of its regular first aid books dealing with the injuries that were likely to occur during a nuclear attack.

But perhaps the greatest civil defence initiative for St. John Ambulance was the Brigade's efforts in blood typing.[38] Nursing (female) members of the Brigade began setting up

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[38] St. John Ambulance called their clinics Blood Grouping Clinics, since they determined to which group a client's blood belonged. The terms 'blood grouping' and 'blood typing' are used interchangeably in this thesis.

clinics to type the blood of the average Canadian citizen. Generally established at industrial sites, the Brigade members would prick the finger of the client to draw blood for the test. Once blood type (O, A, B, AB) was determined, the clients would be issued cards stating their blood type. It was believed that during an attack these clients would provide a ready pool of blood donors. Medical authorities would simply have to put the call out for a certain type of donor, and all those who had the required blood type could report to the appropriate centres, thereby saving valuable time. In addition, should one of these clients be injured in an attack, their blood type would already be known, once again saving time in treatment.[39] Brigade members, somewhat later, began to train in simulated nuclear attack sites, in preparation for acting as rescue squads.[40]

The civil defence program even spread to the cadet corps, the St. John Ambulance youth program. As part of the qualifications for their Grand Prior's Badge[41], the syllabus for this subject expected cadets to have knowledge of civil defence organization, be proficient in clerical ability (especially being able to fill out the appropriate forms) and in firefighting. As well, they were expected to have knowledge in camping, or map reading. Nursing cadets could choose instead to demonstrate knowledge in Child Welfare or Supplemental Hospital Training. In the event of an emergency, cadets were advised to report to civil defence

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[39] Second Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem, 1947, St. John Ambulance National Headquarters, p. 23.

[40] Robert Mustard. *Fundamentals of First Aid*, (Ottawa: St. John Ambulance), 1964, p.2

[41] The Grand Prior's Badge program was similar to the Scouts Merit Badge Program. Cadets (12-15) and Crusaders (16-21) were expected to be "proficient" in twelve subjects to earn their Grand Prior's Badge. It was the only cadet award that could be worn on the adult uniform. Very few cadets actually earned the badge as it took a minimum of three years and the tests for the certificates were quite rigorous. The program continues into the present day.

authorities and perform services as required. If an evacuation order had been put in place, then cadet members would be expected to report to authorities once they had been evacuated. Also new, cadet members were expected to renew their qualifications every year. If they did not take a refresher course within two years, they would lose their civil defence qualification.[42] In no other proficiency was a cadet required to recertify. It is clear St. John Ambulance expected even their youngest members to help in the Civil defence efforts.

The Establishment of the Red Cross

The Red Cross, for its part, was born out of the actions of one man, Jean Henry Dunant. During a battle in 1859 between Austro-Hungarian and French troops near the small Italian town of Solferino, so many soldiers were wounded that the medical resources of the victorious French troops were overwhelmed. Into this catastrophe came Jean Henry Dunant, a Swiss businessman. He was so shocked by the devastation, especially the discovery of five hundred wounded who had been overlooked, that he organized a group of volunteers to care for the patients. These volunteers were urged to ignore the nationality of the patients. All were brothers: "tutti fratelli".[43]

Word of what he was doing leaked out, and within a week 140 civilian doctor's had come to Solferino to help the military doctors. A month later Dunant had managed to organize a medical auxiliary corps consisting of more than 300 people. He did not stop there.

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[42] *Civil Defence*, Cadet Proficiency 1958, St. John Ambulance NHQ

[43] MacKenzie Porter. *To All Men: The Story of the Canadian Red Cross*, (Toronto: McClelland and Stewart), 1960, pp. 17-18

Dunant was so affected by what he saw he wrote a book called *A Memory of Solferino*, which he then published at his own expense. In the book he asked if it would be possible to form an organization that would use volunteers to look after the care of the wounded in wartime. This work would have a greater impact than he could have hoped. The first edition, consisting of 1000 copies, sold out within a month. Publishers from various European countries translated the book, and the work became an international best seller.

Nations from around the world applauded Dunant's actions. In response to the book, a conference was held in Geneva, Switzerland, on October 26, 1863. Twenty-six delegates from seventeen countries attended the conference, resulting in the promise to found voluntary societies that would band together to help out in times of war. August 22, 1864 saw a second conference in Geneva, this time with the involvement of the Swiss government. This conference led to the signing of an international treaty, which came to be known as the First Geneva Convention.

It was decided that the non-combatants responsible for providing medical care (many of them citizens of the warring parties) should wear a red cross on a white field. This symbol was a reversal of the Swiss flag and would therefore symbolize the tenets of the Convention. The organization that emerged out Dunant's efforts took its name from this symbol, the Red Cross.[44]

The Establishment of the Red Cross in Canada

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[44] Porter, p. 17-24.

Canada was committed to the treaty of 1865 by virtue of being a colony of Great Britain[45], but the first use of the Red Cross in Canada occurred twenty years later, during the North West Rebellion, when Dr. George Sterling Ryerson stitched together an improvised flag to indicate he was a medical practitioner. The flag worked well and as Ryerson became disgusted with the state of the militia's medical services, he set about creating a Canadian branch of the Red Cross. Ryerson received permission to do so from the International Red Cross in Geneva, and established the Canadian Red Cross on October 16, 1896.[46] In 1909, the Canadian Red Cross became a charitable organization through an Act of Parliament.[47] It operated as a British subsidiary until 1927 when it was granted autonomy by the parent organization in the U.K.[48]

The Red Cross's Role in Civil Defence

The Red Cross, for its part, saw its role in Civil defence as being an extension of its role in natural disasters and the development of the National Blood Transfusion Service[49] would aid the Red Cross, in its opinion, in both in its Civil defence and disaster roles.[50] In a

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[45] Porter, p. 23.

[46] Porter, pp. 29-31.

[47] Andre Picard. *The Gift of Death: Confronting Canada's Tainted-Blood Tragedy*, (Toronto: Harper Collins), 1995, p. 20.

[48] Porter, p. 36.

[49] Herin after referred to as NBTS.

[50] "Canadian Red Cross Organization and Services" - pamphlet February 1, 1995, p. 10, MG28 I10 Vol.178 File 8.

booklet issued in 1951 to all of its divisions and branches, the Canadian Red Cross laid out its role in Civil defence. The Red Cross was under the control of the government and part of the Civil defence organization. Primarily the Red Cross would be responsible for: (a) the provision of food, clothing and temporary shelter on a mass-care basis during and emergency period, (b) registering disaster victims and dealing with inquiries about them and (c) supplying blood through the National Blood Transfusion Service. In addition the Red Cross committed itself to teaching first aid to Civil defence workers and the general public, and to training [women] in the care of the sick and injured at home.[51] These training programs were to be run in collaboration with St. John Ambulance. The Red Cross was also able to use Civil defence as a means to extend the blood service to the two hold-out provinces (Newfoundland and Saskatchewan).[52]

The Canadian Red Cross also dedicated itself to developing specific tasks at a local level with Civil defence authorities, using what it called "a broad framework".[53] According to its public relations material, specific tasks were to be developed at a later date with local Civil defence authorities.[54] There was also a belief that invoking the cause of Civil defence would

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[51] While the document does not specifically state which sex they would be training in Home Nursing, at this point in time most, if not all of the students in such courses were female. For more information please see Toxopeus, Deanna. "Women in the St. John Ambulance Brigade: Change in a Conservative Organization", B.A. Honours Research Essay, Carleton University, September 1994.

[52] National Executive Committee, *Minutes*, March 13, 1951, 444-12, as cited in *Blood Transfusion Service: The history of the program told through summaries of, and extracts from, minutes of Central Council and the National Executive Committee*, CRC Archives, pp. 25-41.

[53] *The Role for the Red Cross in Civil Defence*, Toronto: Red Cross Society, c. 1951, p.4.

[54] *ibid.*

help increase the level of donations both of blood and money.[55] For their part, Civil defence authorities in the post war period were insistent on a blood reserve being built up, consisting of both whole blood and plasma, as well as the new synthetic products that were beginning to appear in the post-war period.[56] It was a happy conjuncture. By 1961, 20,499 units of dried plasma had been stockpiled for Civil defence purposes in addition to the stockpiles of equipment and supplies.[57] Though concerns were expressed that centralizing the blood banks and storage would make the country's supply vulnerable, these seem to have been ignored.[58]

In any event, the new medical intervention of blood transfusion, which had played such a critical role in World War II[59], would play a central role in the affairs of the Red Cross, St. John and the Canadian State in the post-war period.

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[55] *Minutes of a meeting of National Officer and representatives of the Ontario Division*, Saturday, April 3, 1954, p. 7 & Central Committee, *Minutes*, January 16, 1951, 443-20, as cited in *Blood Transfusion Service:*, p. 41.

[56] Letter from G.F. Amyot, Provincial Health Office and Deputy Minister of Health; to D.J.S. Cull, Assistant National Direct, CRC BTS; dated September 19, 1950; marked confidential, CRC Archives.

[57] W.S. Stanbury. *Origin, Development and Future of the Canadian Red Cross Blood Transfusion Service*, Toronto: Canadian Red Cross, 1961, pp. 3-4, CRC Archives.

[58] Letter from W.R. Fecsby, M.D. to Rockne Robertson, Shaughnessy Hospital, Department of Veterans' Affairs, Vancouver, B.C.; no date, CRC Archives.

[59] Here in after refered to as WWII.

Chapter 3 - The History of Blood Transfusion

The first recorded blood transfusion occurred in 1665, when Dr. Richard Lower (at the suggestion of Sir Christopher Wren) attempted to transfuse the blood of one dog to another. The success of this transfusion has not been recorded. The first recorded human transfusion occurred in 1667 when a boy of fifteen was given the blood of a lamb. That experiment was a disaster, with the boy dying and the doctor who performed the transfusion having to flee a lynch mob. Despite this, the practice of blood transfusion continued, as did the deaths. Eventually blood transfusions were outlawed in France, England and Italy. The Pope, by forbidding blood transfusion in 1678, prevented much further experimentation until the nineteenth century.[60]

The first recorded blood transfusion of the modern era occurred in 1818 when Dr. James Blundell transfused the blood of one man to another. Despite the success of this experiment, blood transfusion still had a high rate of failure, primarily due to the lack of knowledge regarding human blood.[61] At the beginning of the twentieth century, Bordet discovered that blood from one species of animal was not compatible with that of another species. This discovery allowed Karl Landsteiner in 1901 to determine that there were also different types of human blood. The best explanation for the layperson comes from Norman Miles Guiou's unpublished manuscript, *That Others Might Live*.

> The different blood groups depended on two complex sugar molecules (mucopolysaccharides), known as A and B, in the surface layer of the red corpuscles of some people. Most people have none of them and were known as group O. Many had A only, others had B, and a few had both

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[60] Titmuss, Richard M. *The Gift Relationship*, (London, Ruskin), 1970, pp. 17-18.

[61] Titmuss, p. 18.

A and B, and were known as being group AB.[62]

The breakdown in the general population is as follows: O - 46%; A - 42%; B - 9%; AB - 3%. To discover which type of sugar might be contained in the blood, a typing serum was invented. If typing serum was not available, then doctors would perform a cross agglutination test. They would mix samples of the donor and recipient blood. If agglutination (sticking together) occurred, then the blood types were not compatible.[63] It was with this discovery that blood transfusion became a real medical possibility.

In 1913, Lewinsohn discovered that if a donor was bled into sodium nitrate, the blood could be stored and later be given to a patient without causing any harm. This meant that blood could finally be collected and stored for a period of time, allowing for a reserve of blood to be built up. This development effectively increased the amount of useable blood that could be collected from one patient, especially in the case of a burn victim.[64]

Blood transfusion became a semi-regular medical reality during WWI, when soldiers needing blood would receive a direct transfusion from donors lying beside them. This became known as the syringe method.[65] This technique was impractical at best, given battlefield conditions. A new technique of mixing the blood into dextrose and citrate was developed. This technique stopped the blood from clotting, and allowed it to be kept

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[62] Norman Miles Guiou. *That Others Might Live: A Surgeon's Tribute to the Volunteer Blood Donor*, unpublished manuscript, CRC Archives, pp. 11-12.

[63] Guiou, pp. 12-13.

[64] Guiou, p. 14.

[65] Guiou, p. 39.

refrigerated for up to three weeks without it turning toxic.[66] This allowed blood to be collected from a variety of sources and distances and then transported to the casualty in need of treatment. Unfortunately, this technique could only be of use at base hospitals as it was difficult for a military field medic to carry a cooled storage unit for the blood, let alone the glass bottles used for storage.

After WWI blood transfusion began to be used as a regular medical treatment in Canada. Generally, the blood for these procedures was taken from the friends and family of the patient. If the patient had no friends or family, or required more blood, paid donors were available. These donors, tested only for syphilis on a regular basis, were prohibitively expensive and of uncertain quality. If there was no money to pay a donor, then men from a service organization might volunteer.[67]

The voluntary initiative forms a significant chapter in the history of blood transfusion in Canada. The men came from an organization called Toc H. Toc H was a short form for Talbot House, which itself was a British Chaplaincy Service Hostel. Opened in 1915, Talbot House was a club for both officers and enlisted men operating at Poperingh in the Ypres area. Talbot House remained open for the duration of the war. It is not clear when, if ever it was shut down. The house offered a place for men returning from the front to rest and socialize. Its motto was "Abandon Rank All Ye Who Enter Here". After the war, many of those who spent time at Talbot House decided to continue its work in peace time. Their motto became "Spread the Gospel Without Preaching It." As with many British organizations, it spread to

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[66] Guiou, pp. 41-42.

[67] Guiou, pp. 106-107.

Canada.[68]

The Montreal chapter of Toc H began giving blood as the result of a speech given by Dr. Scriver from the Royal Victoria Hospital about blood transfusion. "Toc H became the first organization in North America, apart from local Church groups, etc., to make the voluntary donation of blood its main project"[69]. The members of Toc H also began to express the hope that the Canadian Red Cross would eventually take over the service. This had already happened in Britain, with the British Red Cross taking over the running of the blood service from other voluntary agencies.[70]

It was not until the advent of WWII that blood began to be dried to facilitate storage and transport. In a process, developed in part by Dr. C.H. Best, dried blood could be transported by military medics. The blood could then be reconstituted using distilled water. This made battlefield transfusions a real possibility. The effect can be seen when the casualty statistics from WWI are compared to those of WWII. In WWI, 75 per cent of those who had compound fractures of the femur died. In WWII, 90 per cent of soldiers with the same injury recovered. WWI saw 80 per cent of those with abdominal injuries die, while 73 per cent of those with similar injuries in WWII recovered. Medical officials attributed all of those recoveries to the use of blood.[71]

Perfection of the technique of blood transfusion and the development of the Canadian

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[68] Guiou, pp. 108.

[69] Guiou, pp. 109-10.

[70] *ibid.*

[71] Porter, p. 141.

Welfare State are two, it seems, unconnected events, unless the "logic of industrialism" played a greater role than apparent in the existing record.

Chapter 4 - Creating the Welfare State

There was no one great master plan held by the federal government regarding the establishment of a social welfare system. Ottawa's involvement in the development of Canada's social security system can best be described as cautious due to questions surrounding constitutional jurisdiction and lack of funding. Caution was also part of the residualist heritage of Canadian social policy.

Prior to WWII, a laissez faire or paternalistic attitude dominated Canadian social support. It was believed that those in difficulty were the responsibility of their families or charity. Poverty was seen as being the fault of the individual. The widespread effect of the Depression caused legislators to realize that even citizens who were financially responsible were turning to government relief for help.[72] The Depression caused the weakening of the residual system, which would eventually collapse due to the events both during and after WWII.[73]

In WWII, the Canadian government was forced to assume a much more active role in both the country's economic and social life in order to meet the requirements of the war and the production of war materials. Examples of this control include wage, price, rent and material controls.[74] The government was fully aware of the impact of these controls as they were carefully eliminated after the war, so as not to shock the populace or the economy,

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[72] Dennis Guest. *The Emergence of Social Security in Canada.* (Vancouver: University of British Columbia Press), 1980, p. 83.

[73] Guest, pp. 102-103.

[74] Moscovitch & Drover, p. 27.

thereby preventing a repeat of events following WWI. Rent control was phased out, diluted whisky was not. Rationing of most items was continued until 1947.[75]

Historians have said Mackenzie King had one long term strategy when it came to WWII: avoid repeating the same mistakes as WWI.[76] At the end of WWI, the Canadian government immediately tried to return to the "normal" life of 1914, dismantling the wartime forms of intervention. This proved to be quite traumatic. Returning soldiers glutted a weak labour market due to the end of the war economy and a recession. Widespread unrest resulted.

Canada was not the only country looking to have a more controlled entry into a post-war society. In 1942 the British government released the Beveridge report[77], its plan for post-war reconstruction. Hugely popular in both England and North America, the report identified the five things that stood in the way of a strong post-war Britain: want, disease, ignorance, squalor and idleness. Sir William Beveridge, the report's author, chose to focus on the elimination of want. The three essential elements in eliminating want were a national health service, a system of children's allowances and an economy that would ensure the end of mass unemployment.[78]

The Canadian government was impressed by the Beveridge report, and commissioned

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[75] Morton, p. 226

[76] Bothwell et al. *Canada 1900-1945*, (Toronto: University of Toronto Press), 1987, p. 318.

[77] Sir William Beveridge produced a vast amount of books and reports regarding economics and social policy, but by far the most popular and influential was the 1942 *Report on Social Insurance and Allied Services*. Jose Harris. *William Beveridge: A Biography*, (Oxford: Clarendon Press), 1977, pp.1, 477-479.

[78] Guest, p. 111.

one of its own. *The Report of Social Security in Canada*, otherwise known as the Marsh Report, was presented to the House of Commons Committee on Reconstruction and Rehabilitation on March 15, 1943.[79] Leonard Marsh, the research director for Ottawa's Committee on Post-War Reconstruction, explained that it was a preliminary appraisal and not a blueprint for a new system. Despite this assurance, the Marsh Report was far more encompassing than the Beveridge Report. The report advocated a broad social security system, when supported by a comprehensive employment policy, for the improvement of post-war Canada. Among its recommendations were the implementation of public health plans and sickness benefits to replace lost income and disability pensions. This, Marsh believed, would remove people from poverty and give them and Canada a bright future.[80]

The government publically ignored the report, while trying to achieve some of its reforms. When the Dominion-Provincial Conference on Reconstruction was held in Ottawa in 1945, the federal government made a number of proposals regarding the expansion of Canadian social security programs. Nowhere in any of those proposals was there a reference to the Marsh Report. The main problem the Canadian government had with the report was its centralizing tendency. Marsh's proposals would have taken power away from the provinces, something difficult, given Canada's constitutional reality.

Dennis Guest identifies the most important and influential of the five major themes in

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[79] This committee was set up by Prime minister King to plan for the post-war Canada.

[80] Guest, p. 110-112.

Canadian social security history as that of the impact of the Canadian "constitution".[81] When the British North America Act (hereafter referred to as the BNA Act) was being written, a federal system was settled on, as opposed to a centralized model preferred by some BNA Act politicians. To prevent a repeat of what they felt was the greatest problem with the American federal system - - its emphasis on states' rights - - the BNA Act granted what was then considered to be the most important of powers and responsibilities (defence, criminal law, regulation of trade and commerce, banking, currency, weights and measures, interprovincial transportation and communication, immigration and other areas related to economic development) to the federal government. The Dominion was also granted responsibility and jurisdiction over certain classes of individuals and institutions such as Natives, war veterans and federal prisons. The provinces were given the exclusive responsibility over the administration of justice, regulation of municipal institutions and charitable institutions, and the establishment and maintenance of prisons, hospitals, and asylums.[82]

Health and welfare then was within the jurisdiction of the provinces, likely because at Confederation both were considered a minor responsibility of any government. It was up to the family to support individuals if they fell sick or were unable to provide for themselves. If the family's resources proved inadequate or an individual had no family, then the next step

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[81] The other four themes are as follows:
1. The development of alternatives to traditional means of distributing income, goods and services
2. The social minimum concept - that there is a minimum standard of living that all citizens are entitled to and it is up to the state to provide it
3. Defining, and re-defining, the cause of poverty and dependency
4. The increasing amount of public interest in social programs as they come to be seen as a right.

Guest, pp. 1-5.

[82] Guest, pp. 5-8.

was to turn to the church or charities for aid. Only if these routes were exhausted was an individual then supposed to turn to the government, most likely at the municipal level.[83]

Given this reality, then, it is easy to see why Marsh's proposals created great difficulty for Ottawa. King knew that he would face opposition from the provinces, most noticeably Quebec, and face challenges to the plan's constitutionality if he implemented them.[84] The cost of Marsh's proposals may have also played a role in the governmental rejection. To support the full width and breadth of the report, the annual federal budget would have had to be $2.5 billion. When compared to the pre-war budget (including the late Depression programs) of $500 million, it is easy to see why the federal Liberals balked.

Instead, the Federal Government entered into the 1945 Conference on Reconstruction with the goals of "high and stable level of employment and income and a greater sense of public responsibility for individual economic security and welfare".[85] It would do this by encouraging private industry, establishing a public works program, instituting a series of federal social security programs, and redistributing the taxing powers and revenues between the federal and provincial levels of government.

The public works programs were meant only as a stop-gap measure, to prevent the same sort of mass unemployment that occurred after WWI. The measures would only come into existence when "international or other conditions adversely affected employment"[86]. For

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[83] Guest, pp. 5-8.

[84] Guest, p. 124.

[85] Guest, p. 134.

[86] Guest, p. 135.

the government, this would be in times like depression or war. Full-time employment, according to Ottawa's plan, was the responsibility of industry.

The redistribution of taxing powers meant unconditional federal subsidies in return for the provinces abandoning the fields of personal income taxes, corporation taxes and succession duties. The subsidies would increase or decrease in relation to the GNP. Overall the plan was more generous than the payments made to the provinces under the Wartime Tax Agreements of 1941. There would be an initial trial period of three years, after which the plan would become permanent.

The social security proposals the government put forward were modest when compared to the Marsh Report. The Federal Government planned to provide old age pensions for all Canadians seventy years of age and older. There would be an assistance program for needy Canadians between the ages of sixty-five and sixty-nine. In addition, the federal government would establish an unemployment insurance scheme. Finally, the federal government proposed to share in the cost of a health insurance scheme.[87]

Unfortunately, the 1945 Conference failed. The have-not provinces were eager to turn over the control of their taxes to the federal authorities in hopes of getting the promised social programmes. Eventually Ottawa was able to get seven of the nine provinces to sign. The two holdouts were Ontario and Quebec. Ontario wanted more money and a larger social security program. Quebec's demands were more complicated. Premier Duplessis saw the proposals as damaging to the structure of confederation and was unwilling to hand any more power over to

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[87] Guest, pp. 133-135.

Ottawa.

Due to this impasse, the conference broke up and Ottawa's proposals were shelved. The federal government continued to promise Canadians that the tax arrangements could be negotiated with the provinces. Ottawa also promised that the discussion regarding social security and public investment proposals would continue. But at the time, evolution of Canada's social security was stalled, primarily due to lack of funds and questions of constitutional jurisdiction.[88]

The Evolution of Health Care in Canada

As part of its post-war planning, Ottawa began considering measures for universal health care. The government saw a need for some kind of health care scheme, but was reluctant to get involved due to lack of funds and the constitutional problems it would raise. Once again, caution and creativity were paramount.

Health care had been a part of the Liberal platform since 1919. Though part of the Liberal's post-WWI reconstruction plans, it never came to fruition, most likely due to the fact that it was a promise used to get them elected, not to be kept.[89] At least the Depression saw the creation of medical relief programs in various provinces, but only as temporary programs for those who could not afford to pay. Alberta and British Columbia even managed to pass legislation for provincially-sponsored health insurance, but it was never implemented due to

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[88] Guest, p. 140.

[89] Fraser, Blair. *The Search for Identity: Canada, 1945-1967*, (Toronto: Doubleday and co.), 1967, p. 20.

the resistance of the medical profession.[90]

The end of WWII saw the federal government begin planning for what would become a vast social safety net, part of which was health care. In 1942, Ottawa established an Advisory Committee on Health (Heagerty Committee), in part inspired by the Beveridge Report of Britain.[91] The committee submitted a report to the Canadian government proposing the reorganization of health services. An additional recommendation was that the government pay for a full range of medical benefits including physician, dental, pharmaceutical, hospital and nursing, for a $12 fee.[92] Unfortunately, due to the opposition that was encountered (once again primarily from the medical profession), health care plans were forgotten or put on the shelf.[93]

The problem that Ottawa had was that the constitution had designated health care, along with social welfare, as being a provincial responsibility. The only influence the Federal Government had was as the holder of the biggest purse. It was by creative use of this power that Ottawa got the ball rolling in 1948. By establishing a program of national health grants, Ottawa was able to finance the construction of hospitals "as a first stage in the development of a comprehensive health insurance plan."[94] In addition, these grants allowed for provinces "to

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[90] Robin F. Badgley & C. Charles. "Health and Inequality: Unresolved Policy Issues" in *Canadian Social Policy*, Shankar A. Yelaja (ed.), (Waterloo: Wilfred Laurier University Press), 1987, p. 49.

[91] Jack A. Blythe. *The Canadian Social Inheritance*, (Toronto: Copp Clark Publishing Co.), 1972, p.115 & Badgley and Charles, p. 49.

[92] Andrew Armitage. *Social Welfare in Canada: Ideals, Realities and Future Paths*, (Toronto: McClelland and Stewart), 1988, p. 274.

[93] Bothwell et al., p. 390.

[94] Badgley & Charles, pp. 49-51.

survey their health needs . . . and expand the field of professional training and public health."[95] The 1940s and 50s saw the spread of local medical and hospital association-sponsored health insurance plans. These plans were completely voluntary, in that it was up to the individual to join and pay the fees. Meanwhile provincial governments were instituting plans for both high risk groups (i.e. those on blind pensions) and those with low income.[96]

Saskatchewan implemented a universal and publicly-funded hospital insurance scheme in 1947. British Columbia followed suit in 1949.[97] A national hospital insurance program would not be implemented until 1958. Canadians would have to wait an additional 10 years until 1968 for a national Medicare program.[98]

While the federal government had plans for postwar Canada, in some areas they could be termed as vague. The war had been fought with promises that when it ended life would improve. Unfortunately, there were differing opinions as to what approach these changes should take. Commentators have observed that Canada's social programs came into existence "disjointedly, piece by piece".[99] New programs were implemented at various levels, by both

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[95] Guest, p. 141.

[96] Badgley & Charles, p. 50

[97] Armitage, p. 276.

[98] Although Saskatchewan implemented a universal medicare program in 1962, it was years before the political, legal and constitutional wrangling between the Federal Government, provincial governments and medical profession was worked out, as demonstrated by the doctor's strike in Saskatchewan upon the implementation of that province's universal medicare program in 1962. Badgley and Charles, p. 50.

[99] Allan Moscovitch, "Introduction" in *The "Benevolent State": The Growth of Welfare in Canada*, Allan Moscovitch (ed), (Toronto: Garamond Press), 1987, p. v.

governments and private agencies. If a program in one area became successful, then it might be copied by another region. In this way, social programs spread across the country. The Federal Government then would usually provide funding to all the provinces as a way to make the programs universal. The period between 1945 and 1960 can then be seen as a period where centralization was occurring, whether by intention or not, in Canadian social policy.[100] It was also a time when health care became intimately linked with national defence and the nuclear threat.

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[100] Irving, p. 335.

Chapter 5 - The Beginnings of the Cold War

For Canada, the Cold War began September 5, 1945, when cypher clerk Igor Gouzenko walked out of the Soviet Embassy in Ottawa. Under his shirt he had proof that the U.S.S.R. had set up an extensive espionage network in Britain and North America. Prior to his defection, Canadians widely believed that the post-World War II world would be one of peace. The Soviets, Canadian allies in World War II, had been welcomed after the war in Canada.[101] This acceptance of the Soviet allies helps, in some ways, to explain the reaction of the Canadian government to Gouzenko's accusations. The defector, with his pregnant wife and two-year-old son, trotted around Ottawa for nearly two days before anyone actually believed his allegations.[102] Once this issue came to the attention of Prime Minister William Lyon Mackenzie King, the decision was made to keep it from the Canadian public. The last thing King wanted to do was be responsible for breaking up the wartime alliance.[103] He did however let the other Western powers know about what Gouzenko had revealed.

Canadian public reaction to the Soviets was not unique. They were seen as tenacious fighters, who had endured much at the hands of the Nazis. It is not surprising then that Winston Churchill's 'iron curtain' speech in March of 1946, for many commentators the beginning of the Cold War, was met with such anger.[104] The communist coup in Czechoslovakia in February 1948 forced Canada, and her allies, to publicly recognize that the

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[101] Igor Gouzenko, *This Was My Choice*, (Toronto: J.M. Dent & Sons), 1948, pp. 214-15

[102] Gouzenko, pp. 306-320.

[103] Desmond Morton, *A Military History of Canada* (Toronto: Hurtig), 1985, p. 229.

[104] Fraser, pp. 32-33.

Cold War had begun.[105]

This war would be different from previous conflicts. The advent of nuclear weapons and the shifting geopolitical reality saw to that. Instead, conflict in the post-WWII era would be a game of chess, with the main players using smaller countries as theatres in which to fight their wars, over-shadowed by the nuclear threat. Yet, nuclear weapons, while destructive and terrifying, still had to be delivered by manned bombers. These could be detected and intercepted, and most importantly they were slow. There was time to prepare for attack. Any threat of nuclear weapons, authorities believed, could effectively be countered by a Civil Defence system (even if it underlined Cold War tension). And for the first time in over a century, Canada would be in the line of fire.

Geography had traditionally protected Canada. She was isolated from the conflict that had occurred in Europe in the first part of the century, too far way for the enemy to bother with except in a peripheral way. Traditionally when Canada had gotten involved in wars, they occurred overseas and were to protect or support England and her interests. Technology had also protected Canada. Weapons were not long range or powerful enough to have much of an impact. Those weapons that could cause a great deal of destruction had to be transported to Canadian soil, making it unlikely that they would ever be used.

Both those factors had changed. Canada was the middle ground between the Soviet Union and the United States. There was a great potential of the belligerents using Canadian soil as a pathway get to each other. It was acknowledged that any attack on North America

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[105] Morton, p. 229.

would be a diversionary tactic to draw the U.S. away from Europe, but the possibility of war on Canadian soil was closer than it had been in a century.

Technologically, warfare had changed too. The previous two wars had been fought on the ground by armies on battlefields. The use of planes was to provide protection to the troops from bombers or as a means of destroying production and hurting the morale of the civilians back home. The advent of the atom bomb implied that the next war would be fought in the air, with each side flying the weapons to the opponent's cities. The civilian population moved to the front line. Civil Defence gained stature.

Civil Defence

Some historians believe that up until the Cold War, Canadian Civil Defence was a joke, something to keep the home front busy, making it feel a part of the war effort.[106] For the most part, this analysis is true as the likelihood of Canada being invaded was very small. Two things changed that: the advent of the Cold War and the testing of a hydrogen bomb (which could then be delivered by long-range bomber) by the Soviets. Canada was in the middle between the two combatants. Canadians realized that, for the first time, "they were in the direct line of fire".[107] In addition, the U.S. expected Canada, as part of its responsibility as an ally, to put up some kind of resistance to a Soviet attack. Because of this Civil Defence gained a whole new purpose for military planners.

Winning the next war now depended both on who attacked first, and how many

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[106] Morton, p. 249.

[107] Morton, p. 239.

survived to retaliate. For the Federal Government and the military, Civil Defence became a weapon, and they sought to make it as strong as possible. Millions could be saved "if food, water and medical supplies were stockpiled and if people were sheltered from radiation".[108] In some ways as well, the threat of a nuclear war was used by the federal government to explain the inconvenience and high costs of Civil Defence planning.[109]

When Ottawa began establishing a Cold War plan for Civil Defence, it looked to the benevolent and charitable organizations to help it. The idea that "all agencies of a national character" would have a place in Civil Defence, was very important to planners.[110] Part of this reticence to take on any new responsibility in the health care field was due to lack of money.[111] The Federal Government wanted only a small, full-time administrative staff responsible for Civil Defence that would be attached to the Health Department.[112] Charities were a natural solution since they were more than willing to help, and already possessed the infrastructure and staff to administer programs they were assigned. There was also a push to have Civil Defence authorities plan for natural disasters as well as nuclear attack.[113]

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[108] Morton, pp. 244-245.

[109] Morton, p. 245.

[110] "Sees Red Cross Keystone in Civil Defence Plan", p. 5 in *Despatch*, Vol. 10, No. 4, June-July 1949.

[111] Throughout the Dominion Council of Health Minutes from 1945 through to 1955, the question of who would pay was prominent. It appears that not only was there a shortage of cash both on the federal and provincial levels, but also that neither level of government wanted too many new responsibilities. eg. Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 9, 12.

[112] Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 9

[113] Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 11

The Dominion Council of Health[114] sponsored an initial meeting in 1950 to work out the various organizations' responsibilities. St. John Ambulance, the Boy Scouts, the Canadian Legion and the Canadian Health and Welfare Council met with the government to discuss their respective roles in civil defence. The Canadian Red Cross had been invited, but had chosen not to attend. Instead, the CRC sent a brief outlining what it thought its role should be. No firm commitments were made based on this meeting, as the federal government wanted recommendations from the provincial authorities regarding each of the benevolent organization's competency.[115] Fears were raised that unless the government planned carefully, there could be unnecessary duplication by both government and benevolent organizations.[116] Such duplication could cause confusion, and therefore cost lives, during an emergency situation.

In due course, the participants decided that the work they would perform in post-war Civil Defence would be an extension of their roles had been in the World War II. One of the government's greatest concerns was to ensure there would be enough adequately-trained medical personnel to deal with a disaster. One way to do this was to ensure that there would be at least one person with first aid training in every home.[117] As the Red Cross was already devoting quite a bit of its time to establishing a National Blood Transfusion Service, it made

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[114] The Dominion Council on Health was an advisory board made up of the federal and provincial ministers of health. The board met three to four times a year and discussed health policy.

[115] Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 10

[116] Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 11

[117] *Guide for National Red Cross Societies on their Role as Auxiliaries of the Army Medical and Civil Defence Services*, p. 37 from RG 29, V. 2095 F#20-J-57 Pt. 1 & 2

very little sense for it to also divert energy to training Canadians in first aid. St. John Ambulance had specialised in first aid for quite some time, and had a ready pool of volunteers in the Brigade. In addition, St. John Ambulance had already begun devising a first aid course specifically for Civil Defence.[118]

The Red Cross, for its part, was willing to finance a blood system with little or no help from the various levels of Canadian governments. Even when it began to demand greater funding from the federal and provincial governments, the actual cost was still relatively low as the Red Cross relied heavily on donations from the public and the work of its volunteers.

Cost was also one of the factors working in favour of St. John Ambulance. As a benevolent organization, its costs were also low. In addition much of the training in Civil Defence first aid would be absorbed by industries, as they paid for their workers to take courses.[119] Both of these factors seemed to be the answers to the financial questions regarding Civil Defence and other health matters that were bothering the government.

By the end of 1951, the Dominion Council of Health was recommending the establishment of an advisory council made up of representatives from professional associations, voluntary agencies and governmental groups concerned with health to aid with the planning of Civil Defence. This advisory council was needed, said the Dominion Council Health, "as means of obtaining the support and active co-operation of professional and voluntary

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[118] Dominion Council of Health, 59th Meeting, *Minutes*, January 29-31, 1951 p. 12

[119] *Fifth Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1950, St. John Ambulance National Headquarters, pp. 21-31.

groups".[120]

For Civil Defence purposes, the Red Cross and St. John Ambulance were admirably situated. Both had wartime experience and both felt compelled to carry it into peacetime.

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[120] Dominion Council of Health, 60th Meeting, *Minutes*, November 26 to 28, 1951, Appendix C pp. 1-2.

Chapter 6 - The Establishment of the National Blood Transfusion Service

For its part, the Red Cross began planning for its future as WWII drew to a close, and to this end a post-war planning committee was formed, under the chairmanship of the Hon. J. Earl Lawson. The committee met regularly to discuss what role the Canadian Red Cross would have in post-war Canada. In late 1943, it was suggested that the collection of blood be continued after the war.[121] When discussing the proposal four months later, members of the committee felt they could get support for the plan from veterans who had received so much help from the Red Cross in wartime.[122]

The matter was put on hold until a report was received from the National Blood Donor Committee, a group of volunteers who were responsible for recruiting blood donors for the war effort.[123] The survey results showed that a "vast majority" of Canadian hospitals would welcome a blood transfusion service run by the Red Cross. The report had three conclusions: that the service be of a "national character", that the Canadian Red Cross should be asked to establish the service, and that a doctor be found to run the service. There was a hope that dried serum would also be distributed, but the service's prime focus was to be whole blood. The Committee also felt that Canada would need less blood than it did during the war.[124] There was also discussion of approaching the federal government regarding the use of existing

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[121] Post-War Planning Committee of the Canadian Red Cross Society, *Minutes*, Dec. 13, 1943.

[122] Post-War Planning Committee of the Canadian Red Cross Society, *Minutes*, April 19, 1944.

[123] Post-War Planning Committee of the Canadian Red Cross Society, *Minutes*, October 30, 1944.

[124] National Executive Committee Minutes, April 4, 1945, 417-7, in *Blood Transfusion Service:*, pp. 1-2.

lab space.[125]

The Red Cross was aware that its plans for the blood system might cause some problems. Questions were also raised about how this service might clash with the private and public blood banks already established at some hospitals. These concerns were quickly dismissed. The proposed blood system could, the Red Cross believed, be only of benefit to Canada as it would provide not only an essential modern service, but also an opportunity for the emerging career of blood worker (ie: haematologist, technician, etc.). Members of the committee felt that the only real competition for this kind of a system would be the private, paid donor.[126] Red Cross officials also seemed to know that any objections raised by private blood banks would be met with disgust by the general public.[127]

The report received unanimous approval from the National Blood Donor Committee. It recommended that "the Red Cross undertake the maintenance of a Blood Donor service for the purpose of providing blood banks and blood derivatives for civilian and military hospitals for the benefit of the people of Canada, on a voluntary basis, as a peacetime activity."[128] The committee hoped that by using the existing Red Cross registration service, and a little publicity, they would get all the needed blood without being forced to turn to paid donors.[129]

Interest by the Canadian Red Cross in this kind of a project was influenced by, and

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[125] Central Committee Minutes, May 1945, 65-47, in *Blood Transfusion Service:*, p. 4.

[126] Central Committee Minutes, May 1945, 65-47, in *Blood Transfusion Service:*, p. 5.

[127] For a further explanation and investigation of the situation that occurred in Toronto please see Chapter 7 of this thesis.

[128] Post-War Planning Committee of the Canadian Red Cross Society, *Minutes*, April 30, 1945.

[129] Post-War Planning Committee of the Canadian Red Cross Society, *Minutes*, April 30, 1945.

congruent with, the mandate laid out in the post-war period by the International League of Red Cross Societies (ILRCS) for its members. The ILRCS urged its members to set up and run programs in the health field. These programs were to serve as technical models for future projects and, in line with the international mandate, would be handed over to governmental or other agency control as soon as possible.[130] In 1945, the Red Cross saw for itself three distinctive functions in Canada: First Aid, Blood Transfusion Service (hereafter BTS), and Swimming and Life Saving (with the Royal Life Saving Society). The Red Cross was planning a role for itself in post-war Canada, but insisted that it was "not by 'butting in' or trying to 'hog' projects."[131] This move into the blood system was consistent with what was happening in other countries.[132]

There was considerable domestic support for a national blood transfusion service. Toward the end of WWII, the Canadian Red Cross was approached by "a number of hospitals associations and provincial departments of health"[133] about establishing a civilian blood transfusion service.[134] There was a genuine fear that the medical advances made due to the availability of whole blood and plasma during the war would disappear once the hostilities had

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[130] Stanbury. *Origin, Development and Future*, p. 55.

[131] letter to Nora Lea, Canadian Welfare Council; from P.S. Fisher, Red Cross; dated October 18, 1945

[132] Ross D., Eckert, and Edward L. Wallace. *Securing a Safer Blood Supply: Two Views*, (Washington: American Enterprise Institute for Public Policy Research), 1985, p. 37.

[133] National Executive Committee Minutes, December 12 1945, 425-26, in *Blood Transfusion Service:*, p. 9; W.S. Stanbury. *Origin, Development and Future*, pp. 3-4 & W.S. Stanbury. *A National Blood Transfusion Service: What it means to you*, pamphlet from an address to CBL, Jan 25, 1949.

[134] In addition, a letter was received from the Toronto Labour Council asking for a continuance of the blood system and recommending that blood be given freely. - National Executive Committee Minutes, December 12, 1945, 425-26, in *Blood Transfusion Service:*, p. 9.

ceased.[135] This reflects the broader attitude that a repetition of the mistakes of the post-WWI period not be repeated. The Red Cross had already collected 2.5 million bottles of blood for military use in WWII, so it was the logical agency to run the post-war blood system. A committee was formed to examine the state of blood use in Canada. It had representatives from the Canadian Red Cross, the Canadian Hospital Council, and the Blood and Blood Services Substitutes Committee of the National Research Council.[136]

It is hard to know whether the broaching of the subject by various medical authorities was strictly a coincidence, or whether they were prompted to do so by the Red Cross. Another possibility is that they heard rumours about the Red Cross's investigations, and took the initiative to respond to it. The most likely explanation is that medical authorities had come to realize during the war the value of blood transfusion, and decided (as the Red Cross had) that a postwar blood service would be a benefit. This explanation becomes even more attractive given the increasing use of whole blood and blood products as routine medical procedures at this point in time.[137]

The Red Cross found a doctor with an outstanding set of qualifications to run the National Blood Transfusion Service, Dr. W.S. Stanbury. Dr. Stanbury was most famous for running the blood system in England during the war.[138] The first of his duties in Canada was

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[135] "Blood Transfusion Service Proposed by Canadian Red Cross" in *Canadian Hospital*, Vol. 22, 1945, p. 40.

[136] W.S. Stanbury. *Origin, Development and Future*, pp. 3-4.

[137] Titmuss, pp. 18-21.

[138] National Executive Committee Minutes, May 1945, 420-20, in *Blood Transfusion Service:*, p. 7.

to conduct a survey of the existing resources. When completed, this survey revealed that many parts of the country were without any blood transfusion facilities. One of the reasons for this was the lack of qualified haematologists and technicians in Canada. In areas where facilities, and personnel, existed the actual blood itself was often in short supply. The committee found that in one province, there wasn't enough plasma available to deal with one severe burn case.[139]

Perhaps the survey's most shocking discovery was the high cost of a blood transfusion in Canada, a cost that was prohibitive for most. The practice at that time was for relatives and friends to replace every pint of blood used by a patient with two pints. The patient was charged $25 for every bottle that wasn't replaced. In addition, the hospital would levy a service charge ranging from $5 to $10 per bottle used. Dried commercial plasma cost a minimum of $40 per bottle, and other blood products cost even more, if they were available. The actual cost to the patient was astronomical, as it was not uncommon for a patient to require 20 bottles for one operation. Stanbury's survey discovered that no hospital or government insurance plan was willing to cover the cost of blood transfusion.[140]

From this survey, the Canadian Red Cross developed a plan for a national blood transfusion service. The depot was to be the central focus of the service. Each depot would have a medical director in charge of its operations. In addition to running a clinic out of the depot, trained teams would go to towns and villages in the surrounding area to collect blood from donors. The blood would be grouped, typed and tested for disease at the depot. Once it

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[139] W.S. Stanbury. *Origin, Development and Future*, p. 9.

[140] *ibid.*

had been processed, it would be distributed to major hospitals for use. Smaller hospitals were expected to draw their blood from the supplies of the larger hospitals. Most likely this was done to save the cost of setting up small hospital storage facilities that would get very little use. The Canadian Red Cross was fully prepared to deliver blood using parachutes, if necessary. If the blood had not been utilized within ten days to two weeks, the Canadian Red Cross would collect it from the hospitals and send it to the Connaught Medical Research Laboratories at the University of Toronto to be made into plasma.[141]

There were concerns that the estimated $1 million set-up budget did not take into account the cost of the buildings that would house the depots. This was where the provincial governments stepped in. The Red Cross had received offers of help from several of the provincial governments, but not really having a role for them, had done nothing with these offers. Initial inquiries indicated that the provincial governments would maintain the depots (or provide the money to do so), on the condition the Red Cross staff them.[142]

In addition to the survey of hospital resources, the Red Cross also sent a letter to its wartime donors asking them if they would be willing to participate in a post-war blood transfusion service.[143] This was a follow up letter to one thanking them for their donations during the war.[144] The Red Cross was not prepared to establish a transfusion service without a

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[141] Stanbury. *Origin, Development and Future*, pp. 10-11.

[142] National Executive Committee Minutes, November 1945, 424-23, in *Blood Transfusion Service:*, pp. 8-9.

[143] letter to Donors, from Chair, Blood Donor Committee, no date; entitled *Second Letter to donors.*

[144] letter to Donors, from Chair, Blood Donor Committee, no date; entitled *First Letter to donors.*

large enough donor base to make the service feasible. One of the promises this letter made was that donors would not have to give as often as they had during the war to meet the need.[145] Clearly this letter wasn't just a survey: it was also early publicity for the National Blood Transfusion Service. The Red Cross officials knew that they would not have the patriotic wartime motivation for donors, so that any and all reasons to donate were important.

Canadian Hospital, the journal of the Canadian Hospital Association, was also recommending that blood donor clinics only be set up in towns or cities where there was a minimum of 100 donors per week.[146]

The first public notice that the Canadian Red Cross was planning to establish a national blood transfusion service occurred in *Canadian Hospital*, Vol. 22, 1945. The Canadian Red Cross wanted to know the state of blood transfusion service in Canada, and whether or not Canadian hospitals would welcome the service.[147] As part of the rationale for a Red Cross Service, the article noted that "[t]he Canadian Red Cross Society has already become known as the only national organization providing transfusion therapy but should the society undertake a peacetime service, it will be rendered to hospitals free of charge."[148]

The idea was that savings created by a "free" blood supply would be passed on to patients, thereby dealing with the "class" problem that existed in blood transfusion.[149] While

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[145] letter to Donors; from Chair, Blood Donor Committee; no date; entitled *Second Letter to donors*

[146] "Red Cross Blood Donor Service", p. 29 in *Canadian Hospital*, Vol. 20, 1943

[147] "Blood Transfusion Service Proposed by Canadian Red Cross", p. 37 in *Canadian Hospital*, Vol. 22, 1945.

[148] "Blood Transfusion", p. 40.

[149] "Blood Transfusion", p. 104; "As in War, So in Peace", Pamphlet from CRC circa. 1946.

there was some concern that there would be enough motivation for donors in peacetime, the program was nevertheless endorsed by Dr. Wallace Wilson, the President of the Canadian Medical Association (CMA) and subsequently by the full membership of the CMA at its annual conference in 1949.[150] The service proposed to the CMA was to be modelled on the one that Red Cross had run during the war.[151]

The Red Cross finally published notice of its intentions regarding the National Blood Transfusion Service in its own journal, *The Despatch*, at the beginning of 1946. On the back cover was an elaborate ad with the headline "Red Cross Announces New Civilian Blood Transfusion Service in Canada." The ad went on to say that since millions of lives had been saved during WWII by blood transfusion, the Red Cross was endeavouring to ensure that this service would be continued in peacetime. Pictures accompanying the ad showed soldiers receiving transfusions with captions detailing how the availability of blood and plasma saved their lives. As part of peace-time promotion, one read: "At a front line station this soldier gets transfusion. He and his fellow citizens deserve the same free service in Canada."[152] The ad also announced that the Red Cross had appointed Stanbury, seemingly based on his heading the English service during the war, to head up the Canadian service. It promised free blood for all Canadians. Funding for the service would come from the Red Cross, which had already set aside one million dollars for this purpose.[153] It was hoped to have the blood service set up

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[150] Stanbury. *Origin, Development and Future*, pp. 11-12.

[151] "Red Cross Program In Peacetime Outlined" - November 15, 1947.

[152] back cover in *Despatch* Vol. 7, No. 1, Jan-Feb 1946.

[153] *ibid.*

nation-wide in eighteen months.[154]

With regard to blood banks, the federal government's initial plan in 1945 was to maintain blood banks only in larger hospitals. These banks would provide blood and cross-typing services for smaller hospitals, as well as set up registries for rare types of blood.[155] How then did they, the national authorities, get to the point of endorsing the blood service?

The federal and provincial governments were in favour of this system because of the social reforms that were being instituted or planned, one of which was the improvement of the health care system. They knew that if they wanted to institute these reforms, the availability of whole blood would be important. The proposal by the Red Cross was in some ways a godsend for the various governments. Here was a national agency, with a good reputation, experienced in the field and with broadly-based support from the public offering to establish, fund and manage a nation-wide blood transfusion service. The proposal received the full endorsement of the Dominion Council of Health in 1945.[156]

The National Blood Transfusion Service was seen (and pitched) by the Red Cross as being a four-way relationship. The first of the partners were the provincial governments, which would provide a physical place for the depots and labs. They would also be responsible for building maintenance, or failing that, providing the funds for upkeep. The Canadian Red Cross would be responsible for supplies, technical staff, equipment and transportation, in

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[154] "The Blood Transfusion Service", in *News Bulletin*, Toronto: Ontario Division, the Canadian Red Cross Society, Vol. 4, No. 3, April-May 1947, p. 13.

[155] *Minutes*, Dominion Council of Health, 47th Meeting, May 28 and 29, 1945, p. 47.

[156] Resolution 18 in *Minutes*, Dominion Council of Health, 48th Meeting, Nov 29 to Dec. 1 , 1945, p. 6.

addition to actually collecting, processing and distributing the blood. Canadian citizens would do their part by donating their blood.[157] "The public-spirited men and women of Canada would, it was hoped, give their blood freely and regularly as volunteer blood donors. Obviously, the success of the whole scheme would depend to a very large extent on the altruism of the Canadian people."[158] The final partner was the hospital, which was to administer the blood at no charge to the patient.[159]

In reality, the National Blood Transfusion Service had a fifth partner: the federal government. Co-operation of the Federal Government was essential, as the Red Cross was trying to establish a national system. In order to achieve this they needed an endorsement from Ottawa. The sponsoring of the agreement by Ottawa was that endorsement.

The concept of free blood was fundamental to the plans of the Canadian Red Cross. The chief advocate of this idea was the founder of the blood system, Dr. Stanbury. He repeatedly stressed in all of the Red Cross literature and meetings the need for free blood. Perhaps his most eloquent defence of the idea occurred at a meeting of the National Executive Committee held in January, 1949.

> It is our aim and it will continue to be our aim to provide blood on a national basis to all who require it by way of a voluntary effort, which is the only kind of effort that has ever existed or will exist in Great Britain. It is a British tradition that we should foster rather than the American tradition of paying blood banks, which some of our hospitals have chosen to emulate.[160]

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[157] Stanbury. *Origin, Development and Future*, p. 10 & "Canadian Red Cross Organization and Services"

[158] Stanbury, *Origin, Development and Future*, p. 10.

[159] Stanbury. *Origin, Development and Future*, p. 10 & "Canadian Red Cross Organization and Services" - pamphlet February 1, 1995, p. 10, M128 I10 Vol.178 File 8.

[160] National Executive Committee Meeting - January, 1949, 437-23, in *Blood Transfusion Service:*, p. 16.

Stanbury, like many involved in the medical profession, felt that it was completely unethical to sell human blood, regardless of the reason. Blood was a human tissue, and selling it would be the first step on the road that would eventually lead to the selling of human organs and other body parts. The appeal to British precedents in the wake of WWII was a powerful one, and it prevailed.

The Red Cross strategy proved a successful one in the circumstances and the first clinic was opened in February 1947 in Vancouver, British Columbia, with clinics soon established in Edmonton and Calgary. The following year saw the initiation of blood service in Nova Scotia and Prince Edward Island.[161] In 1948, the Red Cross announced that agreements had been signed with most provinces and it expected to have the national system set up in 12 months.[162] Clinics were staffed primarily by women. At the beginning these were volunteers - many with experience as members of Voluntary Aid Detachments (V.A.D.s) of WWII but as time went on the Red Cross came to the realization that these people would have to be paid.[163] The packaging of supplies for the clinics was done by volunteers (also women) as late as 1952.[164] In addition to the permanent clinics, the Red Cross also began to run mobile clinics. Generally, these mobile clinics would be run out of a permanent clinic, with several technicians driving out to remote locations. Some centres even flew their technicians to

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[161] Stanbury. *Origin, Development and Future*, p. 13.

[162] "Society Spends Ten Million, 1947, Council Hears" in *Despatch*, Vol. 9, No. 4, June 1948, p. 3

[163] National Executive Committee Minutes, January 1949, 437-23, in *Blood Transfusion Service:*, p. 15.

[164] *Despatch*, Vol. 14, No. 3, October 1953.

remote locations in the north.[165]

The Red Cross was able to establish the transfusion service in over half of the Canadian provinces with little to no opposition. Its success lay in the fact that it attempted to work with the other players - - hospitals, doctors and provincial governments. The Red Cross was also careful to cultivate a favourable public opinion regarding the service. In addition, none of these jurisdictions already had established hospital blood banks. Where those existed, the Red Cross ran into strong, sometimes even hostile, opposition.

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[165] "Exercise Yellowknife", in *Despatch*, Vol. 9, No. 5, Summer 1948, p. 3

Chapter 7 - Problems in Toronto

The most serious opposition occurred in 1949, in Toronto, where the Red Cross encountered resistance from area hospitals. Under the NBTS agreement, hospitals were to assume the majority of the liability associated with blood transfusion.[166] This, understandably, caused a great deal of concern. Also of concern to the hospitals was the fact they were not allowed to pass on the cost of blood transfusion to the patient. The Red Cross insisted that blood transfusions cost nothing. To ensure this, the Red Cross had written into its contracts that there was to be no fee charged to the patient. Unfortunately, hospitals incurred costs in the transfusion of blood, including the cost of the technician, the cost of storage, and the cost of the equipment.[167] There were also concerns raised that people who could afford to pay would be receiving the blood free of charge.[168] But by far the most contentious aspect of the contract was the clause that required hospitals to use only Red Cross blood. Hospitals feared that the Red Cross would be unable to meet the demand of a disaster. The Red Cross felt the objections stemmed instead from the money that hospitals hoped to make (and in some cases were already making) from the banks.[169] On a more general level, there were fears raised that a National Blood Transfusion Service run by the Red Cross would be an opening

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[166] Model contract between a Hospital and the Red Cross, from the Red Cross Archives. For the clauses that specifically relate to the relationship between the hospital and the Red Cross, please see Appendix B.

[167] "Red Cross Transfusion Plan Meeting Meets Strong Opposition", p. 58 in *Canadian Hospital*, Vol. 26, January 1949.

[168] letter to Fred W. Routley, National Commissioner, CRC to Col. J.W. Langmuir, Toronto Branch, CRC; dated March 5, 1947; from file "Ontario Hospital Extension 1945-1954", CRC Archives.

[169] "Red Cross Transfusion Plan Meeting Meets Strong Opposition", p. 58 in *Canadian Hospital*, Vol. 26, January 1949.

for "state medicine".[170]

The conflict reached the point that the Red Cross went to the media with its suspicions. The Toronto Hospital Council (hereafter known as the THC) countered with a proposal that the Red Cross and Toronto hospitals jointly run blood banks. This proposal was decisively rejected by the Red Cross.[171] Similar problems were encountered in Montreal, but they ended up being nowhere near as divisive, mostly because the Montreal Hospital Council allowed its members to negotiate individual contracts with the Red Cross.[172] This was not to be the case in Toronto.

Initially, the Red Cross was mystified by the vehement reaction of the THC. Earlier, Stanbury had met with representatives of the Canadian Hospital Council (CHC) to discuss the clauses. It took three meetings, but the three problem clauses were examined and changed by mutual agreement. The Canadian Hospital Council then endorsed the plan and the contract. Despite this, the THC refused to sign. What was even more perplexing for the Red Cross was that one of the people leading the opposition from the Toronto had been at the original meeting with the Canadian Hospital Council.[173]

The Red Cross was concerned with what was going on in Toronto because its citizens donated more money per capita than anyone else, and, as well, donated 20,000 bottles of

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[170] National Executive Committee, *Minutes*, January 1949, 438-8, in *Blood Transfusion Service*:, p. 19.

[171] "Red Cross Rejects Partnership Proposal" p. 37 in *Canadian Hospital*, Vol. 26, March 1949.

[172] National Executive Committee Minutes, January 1949, 438-8, in *Blood Transfusion Service*:, p. 19.

[173] National Executive Committee Minutes, January 1949, 437-23, in *Blood Transfusion Service*:, p. 14.

blood a year.[174] There were clearly fears that this dispute would affect fundraising as well as blood collection. It was felt that the CHC and the THC were neglecting to pass along the best aspects of the National Blood Transfusion Service. The Red Cross went on the offensive, taking the dispute to "the Court of Public Appeal", the Press.[175] Arguments for a national scheme were put forward. It would benefit the smaller hospitals who did not have a large donor pool. It would make all types of blood available all across the country. A national service would make available fractionated blood products, products that could not be bought commercially. It would standardize the equipment and procedures used in blood transfusion, a standardization that had been deemed necessary for civil defence.[176] Dr. Stanbury's statement about following the British example was edited, mostly to tone down any negative comments about the hospitals, and sent to the media. The full statement was distributed to the branches of the Red Cross.[177]

The Red Cross held a meeting with the Toronto hospitals to discuss the problem. The hospitals complained about the service charge and that a lay order would have control of medical services. In addition, the hospitals were upset that the Red Cross had not consulted with the Toronto hospitals prior to establishing the service. Their argument was that Toronto was the largest medical centre in Canada, and had the most experience with blood transfusion.

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[174] National Officers and representatives of the Ontario Division of the Canadian Red Cross Society, *Minutes*, Saturday, April 3, 1954, p. 5

[175] "Blood Transfusion Service" in Ontario Hospital Extensions, 1945-1954, CRC Archives.

[176] National Executive Committee Minutes, January 1949, 437-23, in *Blood Transfusion Service*: pp. 14-15.

[177] National Executive Committee Minutes, January 1949, 437-23, in *Blood Transfusion Service*:, p. 15.

After the Toronto discussion, the Red Cross attended a meeting of the CHC, where they presented their case once again. The Ontario representatives at the meeting used the occasion to attack the NBTS. Meanwhile, the representatives from provinces that had already subscribed to the National Blood Transfusion Service gave nothing but glowing reports. The Red Cross met the old standards for blood transfusion and then surpassed them, while delivering the service more cheaply then previous systems.[178]

By far, though, the largest complaint of the Toronto hospitals about the Red Cross was the bad publicity.[179] Dr. Stanbury had made several statements in the press accusing the Toronto hospitals of greed because they refused to subscribe to the National Blood Transfusion Service.[180] Horrible stories began to appear about children dying due to the unavailability of blood.[181] This shocked and angered the hospitals, who started a vigorous publicity campaign denying that the Toronto blood banks were run by greed.[182] In Toronto, the hospitals said, no-one had been denied blood because of an inability to pay. The CMA stated in the press that they were not opposed to the plan, but were instead opposed to the way in which the plan was introduced. On this ground the CMA had now changed its position, although it had been in

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[178] Canadian Hospital Council, 10th Biennial Meeting, *Transactions*, May 26-28, 1949, p. 106.

[179] Meeting with Toronto Hospital Council, no date, from *Ontario Hospital Extension* from the CRC Archives.

[180] Roy Coltier, "Blood Money", in *New Liberty*, July, 1949, p. 5.

[181] Editorial. *The Telegraph*, May 14, 1949.

[182] "Doctors Opposed Red Cross Taking over Blood Banks", uncredited press clipping, *Ontario Hospital Expansion* at CRC Archives and Dr. Weil, paper given on the Royal Victoria Hospital Transfusion Services at the Women's Auxiliary Meeting, April 7, 1954.

favour of the program initially.[183] The hospitals also raised the question of what would happen if the now centrally-located blood bank suffered a severe fire or some other such disaster.[184] This last point was clearly calculated to counter the Red Cross' assertion that a centrally-located blood supply would be more efficient for civil defence purposes.

After the articles had been printed, Stanbury vigorously denied that the negative statements about the Toronto Hospitals had been made. According to a letter he, along with L.G. Mills, the chair of the National Executive Committee, sent to the THC, the reporter in question had acquired most of his information out of the paper's morgue. In doing so he had misquoted and misunderstood.[185] Through all the controversy the campaign by the Red Cross was beginning to have an affect. Toronto doctors approached the local Red Cross to indicate that they believed the problem was a hospital one, not a medical one. The I.O.D.E. came forward to endorse the free blood service, and the Red Cross took this as an endorsement of its upholding of Clause 15 which stipulated that the Red Cross should be the sole collector, supplier and distributor of blood.[186]

The strong reaction of the Red Cross to the Toronto hospitals in part stems from the fact that the Toronto area was its largest donor of money and blood. If the National Blood Transfusion Service was to be a success, it was essential that the Toronto hospitals be

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[183] Dr. Weil, paper, April 7, 1954.

[184] letter from W.R. Fecsby, M.D. to Rockne Robertson, no date

[185] letter from L.G. Mills, Chair, National Executive Committee, CRCS & W.S. Stanbury, M.D., National Commissioner, CRCS; to C.A. Sage, Secretary, Toronto Hospital Council; dated April 5, 1954.

[186] National Executive Committee, *Minutes*, January 1949, 438-8, as stated in *Blood Transfusion Service*:, pp. 17-18.

involved. Furthermore, the Red Cross was having more problems getting donors at the time than during the war.[187] The addition of Toronto would be a great boost to the program. For Toronto Hospitals the issue was money. The blood banks were profitable, and those profits would help erase deficits incurred in other parts of hospital operations.[188]

Despite the difficulties the Red Cross encountered, the situation was eventually resolved as Toronto was a part of the service by the end of the 1950s, though the nature of the resolution remains unclear. What is clear is that the Red Cross had to deal with this problem. Any stalling could be detrimental to the NBTS, and to the funding situation.

Funding

Initially the Canadian Red Cross Society envisioned the National Blood Transfusion Service as being completely financed by its funding campaign, as it was during the WWII. By 1950 the Red Cross was having increasing difficulty in funding its operations. At the same time as it was setting up the blood system, the Red Cross financed nursing stations for those areas of the country that did not have ready access to medical care, provided disaster relief both in Canada and abroad, and supplied escorts for war brides coming to Canada. It also provided funding to organizations such as St. John Ambulance to aid in their operations. In this case, the money provided to St. John was for both its work in Home Nursing and First Aid instruction and the Brigade.[189] Meanwhile the NBTS began to take up an ever-increasing

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[187] Central Committee Minutes, June 1947, 69-36, in *Blood Transfusion Service*: p. 11.

[188] Transactions of the Canadian Hospital Council, 10th Biennial Meeting, May 26-28, 1949, p. 105.

[189] *Give* - Pamphlet from the CRC circa 1950. MG28, I10, Vol.178, File 7

part of the CRCS budget.

It was only natural then that the provincial divisions began to complain about the amount of money being spent on the National Blood Transfusion Service[190], by 1951, some forty-six cents of every Red Cross dollar spent.[191] In addition, there had been a significant drop in both blood and money donors. Several different plans to increase blood and financial donors were proposed, the most popular of which was the establishment of donor clinics in hospitals to allow the family of recipients to donate. This was eventually rejected as it would be a step back to what existed before.[192] It would also be giving in to the demands of the Toronto Hospital Council. There were worries that the costs would be the downfall of the Red Cross in Canada, and there were calls to close down the NBTS.[193]

When the cuts came to CRCS services, the National Blood Transfusion Service was spared. Divisional budgets suffered a 10% cut; the exceptions were disaster relief and blood services. The National Blood Transfusion Service was, however, affected in other ways. A resolution was passed that there would be no expansion of the system unless there were adequate funds available.[194] This was put to the test when Newfoundland asked about getting blood. Canada's newest province was told, in no uncertain terms, that until the government provided the money and the premises, the National Blood Transfusion Service would not

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[190] National Executive Committee, *Minutes*, January 1949, 437-26, in *Blood Transfusion Service:*, p. 16.

[191] Central Committee, *Minutes*, November 1951, 78-35, in *Blood Transfusion Service:*, p. 46.

[192] Central Committee, *Minutes*, November 1951, 78-35, in *Blood Transfusion Service:*, p. 48.

[193] Central Committee, *Minutes*, November 1949, 74-43, in *Blood Transfusion Service:*, pp. 25-27.

[194] Central Committee, *Minutes*, November 1951, 78-35, in *Blood Transfusion Service:*, p. 48.

expand into Newfoundland.[195]

The national officers of the Red Cross also began to look for alternate means of funding. They asked for $500,000 from the military to pay six months in advance for plasma destined for Korea. Despite the fact that such an amount would have to be approved by Privy Council, the Red Cross was confident that funds would be provided. The reason for the confidence on the part of the Red Cross is most likely due to the fact that the co-ordinator of civil defence had already made it known that they were willing to underwrite the blood program for up to a million dollars.[196] Clearly, the Canadian government felt that a national blood transfusion service was important enough for civil defence purposes to fund. It was agreed by both parties that the source of the money would not be publicized as it might jeopardize the Red Cross public funding drives.[197]

The Red Cross knew that the then-current method of financing could not continue. A suggestion was made that the Red Cross ask the federal government for funding, but to do it quietly. There were worries about such a move, as the Red Cross did not want to be seen as selling blood, even to governments.[198] But they rationalized such an approach on grounds that a huge amount of blood was being supplied by the Red Cross both for the purposes of Civil Defence and for military use in Korea. In addition, the Federal Government had set aside

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[195] Central Committee, *Minutes*, November 1951, 78-45, in *Blood Transfusion Service:*, p. 49.

[196] *Extract from Minutes of the National Officers held on September 21, 1950*; CRC Archives.

[197] National Executive Committee, *Minutes*, January 16, 1951, 443-20, in *Blood Transfusion Service:*, p. 41.

[198] Central Committee, *Minutes*, November 1951, 79-30, in *Blood Transfusion Service:*, p. 50-51.

$2,250,000 specifically for the purchase of medical supplies for Civil Defence. This sum included money for blood transfusion equipment.[199]

Eventually the Red Cross informed National Defence and Health & Welfare that unless an additional subsidy of $200,000 was guaranteed, there would be no commitment to supply plasma to either department in 1953. In addition, both departments were informed that unless the guarantee was received within 90 days, the Chorley Park Depot in Toronto would be scaled back to meet civilian needs. This last warning carried a lot of weight as it was the Chorley Park Depot that supplied the majority of blood to the two departments. The government found the money.

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[199] Dominion Council of Health, 61st Meeting, *Minutes*, April 21 to April 23, 1952, p. 9.

Chapter 8 - St. John Ambulance In the Post War Era[200]

As St. John Ambulance looked towards the post war era it saw a greatly-expanding role for itself. WWII had brought an increased membership and visibility in Canada. The Association (the training arm of St. John Ambulance) began to push its courses while the Brigade (St. John Ambulance's voluntary service branch) began to look for a role for its vastly increased membership. For the female members (referred to in St. John as Nursing Members), that role was initially in blood grouping clinics.[201]

St. John did not just go around setting up blood grouping clinics. Generally St. John Ambulance would be approached by a local factory or business to set up such a clinic. At the appointed date and time, the nursing members would appear, usually at the factory or office and set up shop. The employees would then enter and have their finger pricked, in order to draw a sample of blood. Based on the reaction of the solution to this sample, the nursing member would determine the employee's blood type. Employees would be issued a card stating their blood type and be told to carry this with them at all times. When a specific region adopted Rh testing (the negative or positive factor), this information would be added to the card.[202]

The purpose of this card was twofold. It would serve as a reminder to the employees of their blood type. When authorities (such as Civil Defence agencies or hospitals) put out a call for

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[200] Unfortunately the information on St. John Ambulance will not be as extensive as that on the Red Cross as the St. John Executive Committee Minutes from 1945-1955 are still classified as confidential. An attempt was made by the staff at National Headquarters to get copies of the Priory Chapter Minutes for that period, but they could not be located in time for this thesis.

[201] The terms blood grouping and blood typing are used interchangeably in this thesis.

[202] *Third Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1948, St. John Ambulance National Headquarters, p. 34.

blood of that type, the employees would know whether or not they had to report. More importantly for the employees though, should they ever be injured, this card would quickly identify to authorities what their blood type was, saving valuable time that could save their lives.[203]

In return for setting up and running the clinic, the factory or office would quite often provide a donation to St. John Ambulance to cover costs. These were lower than they would have been had local health departments or hospitals run similar clinics as all of the staff at these clinics were volunteer. The service as a whole was overseen at the national level by a doctor, but at the local level most clinics were run by nurses.[204] As with the clinic staffers, the supervisory personnel were volunteers.

This service began to occupy more and more of the Brigade's time, primarily that of the nursing members. Most of St. John's provincial headquarters reported that blood grouping was taking up the majority of Brigade member's time.[205] Of all provinces, Manitoba embraced the practice wholeheartedly, to the extent of organizing airlifts of clinics to remote areas of the province.[206] By 1949 St. John Ambulance had typed 200,000 individuals since the inauguration

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[203] *Second Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1947, St. John Ambulance National Headquarters, p. 23.

[204] *Twelfth Annual Report of the Commandary in Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1945, St. John Ambulance National Headquarters, p. 9.

[205] *First Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1946, St. John Ambulance National Headquarters, pp. 23-34.

[206] *Third Annual Report*, 1948, p. 64.

of the service in 1943.[207]

But despite its success, St. John Ambulance shut down the blood grouping programme in 1951. According to St. John Ambulance's records, this was done independently of the Red Cross agreement. Apparently St. John's medical adviser, Dr. W.P. Warner (the man who had earlier chaired the negotiations leading up to the 1951 agreement[208]), recommended that the service be shut down. Margaret MacLaren[209], a member of the St. John negotiating committee, claimed the reason for the shut down was due to the high percentage of error in typing that was occurring in these clinics.[210] The Red Cross had already identified this as a problem,[211] but this was the first time that St. John had acknowledged it.

In some provinces the blood grouping clinics continued to operate until the Red Cross National Blood Transfusion Service had begun operations, perhaps as a way to maintain interest in blood donation. St. John's attitude in relation to the NBTS was one of "co-operation and goodwill".[212] But there was still some opposition to retiring from the program, most likely due

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[207] *Fourth Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1946, St. John Ambulance National Headquarters, p. 17.

[208] Please see Chapter 11 of this thesis for more information on the negotiations leading up to the agreement.

[209] MacLaren was one of the five St. John Ambulance representatives on the Joint Technical Committee that negotiated the agreement. Her first appearance in the record occurred in WWII when she became one of the nine officers taken by Kay Gilmour (in charge of all nursing divisions for Canada and head of the St. John Ambulance Voluntary Aid Detachments - V.A.D.s) to England in 1944 as the initial step in setting up a Canadian V.A.D. service. Since all of these women were already members of the Brigade, MacLaren's association with St. John predated this time, but this was her first initiative at the national level. She stayed on and became a staff officer in London, eventually taking over as Lady-Superintendent-in-Chief (the head of the female side of the Brigade) when Gilmour stepped down. MacLaren, p. 1 & Nicholson, pp. 114-117.

[210] MacLaren, p.2.

[211] National Executive Committee Minutes, March 13, 1951, 444-14, in *Blood Transfusion Service:*, p. 42.

[212] MacLaren, p. 2.

to a concern as to what the new role of the nursing members would be.

As previously stated, blood grouping had become the primary role for the female members of the Brigade. With the 1951 agreement that role was gone. In some provinces the nursing members began to assist at the new Red Cross blood clinics.[213] In others, the Nursing Members shifted their focus to Home Nursing training and volunteering in hospitals. Women did move into volunteering in hospitals and nursing homes, but as the medical workers (ie. nurses, nursing aspirants) became increasingly more professionalized, these areas were closed. The only role left to them in St. John Ambulance was as a first aider.

The Rise of Industrial First Aid

Modern first aid originated out of military medicine. War planners became aware that if first aid was rendered to soldiers soon after injury, then their chances of survival increased exponentially. If they survived, then they could return to the battlefield and fight again. This was advantageous for reasons of economy and efficiency, as training the soldier's replacement would cost a great deal of money and time. The military thus sought to improve the medical training of its soldiers, creating the positions of military doctor, nurse and (most importantly for the discussion of first aid) medic.[214]

To aid the military, the Order of St. John of Jerusalem[215] began to train ordinary civilians

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[213] *Fourth Annual Report*, p. 20.

[214] *First Aid: Safety Oriented, First Canadian Edition*, (Ottawa: St. John Priory of Canada Properties), 1983, p. v

[215] This is the parent organization of both the St. John Ambulance Association and the St. John Ambulance Brigade. As time went on and the Order spread, it increasingly became known as St. John Ambulance, although it

(mainly men) in first aid. These trainees were to make up a ready reserve of first aiders for the military to dip into in case of war. The trainees were not content though to simply sit and wait for war to occur. Perhaps because of their enthusiasm and patriotism, or perhaps because they wanted to practice their skills, the trainees began to show up at large public events and provide first aid to the crowds. St. John Ambulance decided to organize these volunteers, most likely to both standardize equipment and training and gain control over the group's activities.[216] This is what would eventually evolve into the St. John Ambulance Brigade.

At the same time, a German physician by the name of Dr. Esmarch began to advocate the use of first aid to help bring down the high casualty rate in factories and industry. To this end he wrote *Lectures in First Aid*, a text and syllabus meant to be used by industry. This book proved to be a runaway success, being translated into the majority of European languages. St. John Ambulance used it for a time as a supplemental text.[217] Dr. Esmarch was in turn impressed by the work of the St. John Ambulance in Britain and began establishing civilian reserves back in Germany, modelled on the Brigade.[218]

St. John also began producing medical equipment to be used by industry and municipal government in the treatment and transport of the injured. Their most popular product was a stretcher with two large wheels which was easy to use and manoeuver. What became known as the "St. John Ambulance" won awards all over Europe and financed the Order's activities in

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is still officially known as the Order of St. John of Jerusalem. At this point the Order existed only in Britain.

[216] Fletcher, p. 27.

[217] Fletcher, p. 27.

[218] Fletcher, p. 34.

England for quite some time. This stretcher eventually gave its name to the Order.[219]

For some reason, industry never really embraced first aid at this time. Those workers who took training appear to have done this on their own time and paid for it with their own money. It wasn't until after WWII that industry realized the advantages of first aid. Perhaps due to the publicity generated by first aid used during the London Blitz[220], perhaps due to patriotism and a sense of duty spawned by Civil Defence[221], or perhaps due to studies that showed that first aid training helped reduce accidents[222], industry finally adopted the idea of first aid. St. John was flooded with requests to teach first aid in the business setting. The employers would not only pay for these courses, but would allow their workers to take the courses during the workday.[223]

By making St. John Ambulance the official first aid trainer for Civil Defence, the federal government provided it with a huge amount of business. All government workers, as well as all police, fire and military personnel were to be trained by St. John. The 1951 agreement also gave the Brigade the exclusive right to provide first aid at public events and gatherings.[224] Since all of these activities were fundraisers for St. John Ambulance, the organization also obtained a secure source of funding for the foreseeable future at the same time as they provided a post-war role for

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[219] Fletcher, p. 27.

[220] Nicholson, p. 113-115.

[221] *Seventh Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1952, St. John Ambulance National Headquarters, p. 24.

[222] Nicholson, p. 171.

[223] *Sixth Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1951, St. John Ambulance National Headquarters, p. 20-34.

[224] MacLaren, Appendix, pp. 2-3.

their female members.

The Gender Neutralization of First Aid

The 1951 agreement was, therefore, also the start of the gender neutralization of first aid. Traditionally first aid was an all male preserve. Male members of the Brigade (known as Ambulance Members) trained exclusively in the treatment and transportation of casualties. Prior to 1951, when women were taught first aid it was as a supplemental subject. As the traditional female roles began to disappear, St. John Ambulance had to allow its nursing members to move into the first aid realm. At first, it was still primarily the "feminine" side of the treatment of casualties, that is bandaging wounds, but as time went on women began to move into the traditional male sections of first aid, including transport and lifesaving.[225]

In her eighteen years in the position of Lady-Superintendent-in-Chief (later Superintendent -in-Chief), it was Margaret MacLaren who not only helped negotiate the 1951 agreement and later to manage it, but was instrumental in leading St. John Ambulance, and especially its female members, in the post-war world. Under her leadership, female membership in the Brigade increased despite the loss of the blood-typing clinics. She encouraged (if not insisted) that St. John keep abreast of the latest medical developments. She also encouraged St. John Ambulance to work with other agencies to aid the handicapped. MacLaren also did not hesitate to get rid of a program if it proved no longer to be of any use to St. John Ambulance or Canadian society as

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[225] Toxopeus, pp. 60-65. For a further discussion on how exactly this occurred, please see *Women in the St. John Ambulance Brigade.*

a whole (for example the closing of the Blood Grouping Service).[226]

MacLaren continued to serve St. John Ambulance until the day before she died in October 1963, when she resigned from her position as Superintendent-in-Chief.[227] But through her work with the Brigade, especially the agreement she, more than anyone else, had defined St. John Ambulance's post-war role in Canadian society by directing it away from the field of blood typing towards the expanding (and increasingly profitable field) of industrial first aid. It was also a field that, due in part to her efforts, would become one of interest to both men and women.

The Brigade as a whole was also prepared for its role as civilian disaster reserve - including Civil Defence - by the St. John publications, *Canadian First* Aid and *St. John News*. These publications were aimed at the average Brigade member. Issues generally covered who was receiving what awards, what new programs were being brought in and first aid hints. Articles on Civil Defence and what would be expected of the Brigade in case of nuclear attack were also carried. There were photo essays of members practising in simulated nuclear blast sites.

The first aid texts took longer to change. The reason for this was that new texts were only produced when techniques changed. Still they began to reflect the advent of civil defence and the threat of nuclear war.[228] Many of these initiatives formed part of the background to the 1951 agreement.

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[226] Nicholson, p. 134.

[227] Nicholson, p. 135.

[228] Toxopeus, pp. 72-73.

Chapter 9 - The 1951 Agreement

G.D.W. Cameron[229], the Deputy Minister of National Health and Welfare, gave no reason for suggesting a round of discussions between the Red Cross and St. John Ambulance in 1949, but both organizations agreed to send representatives to a meeting in his office in Ottawa. The two agreed to attend, according to Margaret MacLaren, in hopes of dealing with the "confusion and conflict . . . created in the minds of the public"[230] in regard to the role of both organizations due to their direct competition with each other. Dr. T.H. Legget, the Honorary Medical Advisor to St. John Ambulance, and Dr. Stuart Stanbury, the National Commissioner of the Canadian Red Cross represented their respective organizations, and by the end of the meeting both agreed that something had to be done.

Both men returned to their own organizations and, within one month, the first meeting of the Joint Technical Committee was held. The committee's mandate was to negotiate an agreement to define the role of both St. John Ambulance and the Red Cross in Canada. With Dr. W.P. Warner (who, at the time, was not affiliated with either organization, although he would later go on to work with St. John Ambulance) as the chair, the Committee met three times (April 20, 1949, May 5, 1949 and Jan 11, 1950). Between those meetings, drafts and memos were passed back and forth. The agreement worked out was submitted to both organizations for approval and then handed over to legal counsel for formal preparation. On

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[229] It is not clear whether G.D.W. Cameron may have been at this point been associated with St. John Ambulance, but by 1957, Cameron was serving as a member of the St. John side of the Joint Operational committee. Dr. Cameron was also associated with the Red Cross during his tenure as Deputy Minister, primarily as a board member.

[230] MacLaren, p. 1.

January 26, 1951, the agreement was signed. In less than two years, the landscape of Canadian health care underwent a significant change.

The Canadian Red Cross voluntarily surrendered the first aid aspect of its program and St. John Ambulance gave up the blood grouping clinics, by then a significant part of its Brigade activities. The Canadian government sponsored the agreement, thereby granting monopolies in the health care system to two private organizations. There were also financial implications.

By 1950, the Canadian Red Cross was experiencing a significant shortfall in its funding drives. This shortfall becomes even more significant when one realises that the Canadian Red Cross was funding almost the entire National Blood Transfusion Service from its own coffers, a feat that very few other countries had been able to duplicate.[231] In Australia, the Red Cross was running the blood program, but with 90% of the funding coming from the government. In the U.K., the government ran the blood system completely. In the U.S., the Red Cross distributed approximately 40% of all blood, but the system was, at this point, still dominated by the private, for-profit clinic.[232]

In addition, for the Red Cross, the agreement meant that a rival with a radically different philosophy was withdrawing from the market. While St. John's portion of the market share was fairly small, it was more than willing to do mass blood grouping for the Civil Defence authorities, a practice the Red Cross frowned on because it left room for too

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[231] Stanbury. *Origin, Development and Future*, pp. 31, 54.

[232] Stanbury. *Origin, Development and Future*, pp. 32-29.

many mistakes.[233] St. John's blood grouping was done primarily in industry, a practice that the Red Cross felt was taking donors away from its clinics.[234] The agreement meant that now the Red Cross could dictate the terms by which blood would be collected and tested in Canada.

For St. John Ambulance blood grouping had become a major activity, especially for the Brigade. By 1949, approximately 200,000 people had been typed by the Brigade.[235] Accordingly, St. John was spending an ever increasing amount on the running of the blood grouping clinics.[236] In Ontario, Brigade members had even begun testing for the Rh factor in blood.[237] Additionally, enrolment in first aid courses was down, although this was somewhat expected with the cessation of hostilities at the end of WWII. This was worrying, as first aid courses were one of the ways in which their other efforts were financed. There seemed to be no discernable dividend for St. John from its war efforts.

The agreement gave St. John a guaranteed client for its first aid courses, the Federal Government. All government departments that required their employees to obtain first aid certification would have them certified through St. John. This would later be extended to crown corporations. St. John Ambulance also became the listed government standard for first aid requirements. This meant that a St. John Ambulance certificate became a legal

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[233] National Executive Committee, *Minutes*, March 13, 1951, 444-14, in *Blood Transfusion Service:*, p. 42.

[234] MacLaren, p. 1.

[235] *Fourth Annual Report*, 1949, p. 17.

[236] In 1945 the cost of blood typing was $1,691.06. By 1950 the cost had risen to $6,020.91. - *Twelfth Annual Report*, 1945, p. 44 & *Fifth Annual Report*, 1950, p. 40.

[237] *Third Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem - 1948*, p. 34.

requirement for certain jobs.[238] St. John had hoped that the Red Cross would have retired completely from the first aid field, but was happy to have the realm of industry (including police, military and firefighters) to itself. In St. John's opinion, it had left the diminishing field of blood grouping[239] in exchange for the expanding one of industrial first aid.[240] Whether officials like MacLaren realized it at the time, this would reshape the organization.

For the Federal Government, the agreement achieved the efficiency required for Civil Defence. They had a single source for blood (and the ever-increasingly-used blood products) as well as standardization of transfusion equipment. In addition, they established one standard for first aid training, something considered important in 1951, even though its importance would later decrease with the development of the missile to deliver nuclear warheads and diminished warning times. As the chance for survival decreased, Civil Defence seemed less important. All of this was achieved with, initially, little or no expenditure of money. Ottawa had successfully instituted a new health care program without spending any money and without getting into a fight with the provinces.

The St. John Ambulance - Canadian Red Cross Joint Operation Committee was then established to manage the agreement. This committee was responsible for resolving disputes that would arise from the agreement. For example, in May 1961, the Red Cross moved its

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[238] Later these types of requirements would be amended to read St. John Ambulance or its equivalent to reflect the abandonment of the agreement.

[239] The blood grouping program was going to be shut down eventually, as Dr. Warner (by then the St. John Ambulance medical advisor) who had been in discussions with medical officials had become convinced that blood grouping allowed for too many errors.

[240] MacLaren, p. 2.

"Water Safety Week" from its traditional summer slot into the same week as St. John Ambulance held its "Save-A-Life-Week".[241] This may seem a trivial matter, but as both initiatives attracted a great deal of publicity for both organizations, they were in fact major events on the calendar. Prior to 1951 neither organization would have any way to redress this matter, but with the agreement in place there was a speedy and satisfactory solution: The Red Cross moved "Water Safety Week" and agreed not to conflict with "Save-a-Life-Week" again.[242] The Joint Operational Committee continued to operate until 1963. The record does not indicate how problems that arose were dealt with or if they were dealt with at all.

The 1951 Agreement itself continued until 1973 when the Red Cross informed St. John Ambulance that it would not be renewing the agreement. From that point on, both organizations competed against each other in the first aid field. St. John did not re-enter the blood typing field as it had lost most of its expertise. Nor did they really want to incur the cost of purchasing equipment and training personnel.

Allan Moscovitch has said that "the history of social welfare in Canada is the history of first private and then public welfare, the expansion of both, and the absorption of the private by the public".[243] What was happening here, whether the government realized it or not, was that the state was stepping in to regulate two new areas of medical services. The government,

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[241] MacLaren, p. 8.

[242] Interestingly enough, MacLaren was only one of two women on the Join Committee (the other being Miss H.G. MacArthur, the National Director of Nursing Services for the Red Cross). With the implementation of the agreement, MacLaren then became a member of the St. John Ambulance - Canadian Red Cross Operation Committees. She became the only member to attend all of the meetings. When the committee ceased to meet, she wrote an impassioned plea to renew the meetings.

[243] Moscovitch, *Welfare State*, p. v

by endorsing the agreement, established the Red Cross as the blood supplier for the nation and St. John Ambulance as the first aid authority. By doing so, it was taking the first step toward, at least partially, absorbing two private welfare organizations into the public welfare state, through initially with indirect financial support (the Civil Defence blood reserve and the first aid contract for the public service). Such support was wholly within federal jurisdiction. There were no provinces with which to negotiate.

Chapter 10 - Conclusion

By 1955 the National Blood Transfusion Service had spread to seven provinces, and served large areas of two others.[244] The total value of the blood products distributed by the Canadian Red Cross between February 3, 1947, and December 31, 1960 was $93,888,980.[245] First aid courses were only offered "as mutually agreed upon with St. John Ambulance Association".[246] It is possible to see that the Canadian program had an influence internationally as the International Red Cross Conference held in Stockholm in the summer of 1948 adopted a resolution recommending that member societies take an active role in blood transfusion. The recommended model at the conference was co-operation with government or, failing that, creation of an independent organization. Above all, the blood was to be free.[247] Clearly the conference was using the Canadian model. In fact, when the British system underwent modifications it followed the lead set by the National Blood Transfusion Service.[248] In addition, officials from other countries came to Canada to study the Red Cross NTBS.[249]

For St. John Ambulance, the 1951 agreement provided an initial jump start to its first

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[244] "Canadian Red Cross Organization and Services" - pamphlet February 1, 1995, p. 10, M128 I10 Vol.178 File 8.

[245] Stanbury. *Origin, Development & Future*, p. 58

[246] "Canadian Red Cross Organization and Services" - pamphlet February 1, 1995, p. 10, M128 I10 Vol.178 File 8.

[247] Joint Report on Action Taken on the Resolution of the XVIIth International Red Cross, (Stockholm, August).

[248] Brief on the Blood System - *Ontario Hospital Extension*, Red Cross Archives.

[249] "Brazil Doctor Studies Canada's Blood Service", p. 6 in *Despatch*, Vol. 10, No. 4, June-July 1949

aid programs. Not only were the various levels of government sending their employees to be trained by St. John, but industry was turning to it to train its workers as both part of Civil Defence initiatives and an increasing awareness of industrial safety. With the addition of marketing ideas such as "Save-a-life Week", more and more people were certified. In 1952, one year after the agreement St. John Ambulance certified 66,786 people.[250] By 1960, the annual number of certificates had climbed to 115,751 granted.[251]

In addition, problems between both organizations were also being dealt with efficiently and without much animosity, such as the conflict between St. John's "Save-a-Life-Week" and the Red Cross "Water Safety Week" in 1961.[252]

Ottawa also benefited from the agreement. It had an increasing supply of blood and trained first aiders in case of disaster. The federal government also had achieved efficiency in a portion of the nation's health care system without incurring any opposition from the provinces. This efficiency was becoming increasingly important as the Cold War deepened and attack looked more and more likely. All of this was achieved with little to no financial commitment by Ottawa.

Why?

Is there a theoretical framework with which to understand the agreement? The framework laid out by Struthers is useful, though no one theory can be used to explain the

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[250] *Seventh Annual Report of the Priory of Canada of the Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem*, 1946, St. John Ambulance National Headquarters, p. 44.

[251] *St. John Ambulance in Canada*, Annual Report, 1960. St. John Ambulance National Headquarters, p. 44.

[252] See "The 1951 Agreement" for further details.

1951 agreement. All have merit at different points.

The hagiographic style of interpretation can be used to explain the motives of certain key players in the agreement, specifically Stansbury, MacLaren and Cameron. All three may have had, in some way, the best interests of Canada in mind when it came to the agreement. The Social Democratic school, except in so far as general pressure created by the CCF and labour backed a drive for post war reform, is not very helpful in understanding this agreement in a specific sense. From the available material, it appears that organized labour, at least indirectly through the CCF, does not play a role in the emergence of this agreement. Feminist interpretations of social history help us to understand the importance of Margaret MacLaren, a woman who held a very powerful position in a conservative organization, as well as the role of the women who played such an important part in St. John's WWII efforts. It also allows us to understand why the women's role (Blood Grouping) might be sacrificed for the good of the organization and how these women were then able to move into first aid, thereby making this previously all male preserve gender neutral. It is even possible to evaluate the agreement using Marxist theory. Blood and blood products would be available at little to no cost to the general public. All of these theories, while helpful in understanding small sections of the agreement are not as useful as understanding the agreement as a whole.

Three of the frameworks identified by Struthers appear more central: the Logic of Industrialism, the Political Culture and State Centred approaches.

The logic of industrialism school helps us to understand how the government chose to deal with the advent of the new technology of blood transfusion. It was clear that various parties did not want to lose the benefits that blood transfusion had given them, so an attempt

by the government to legislate or control was a natural outgrowth of the increase in the use of this technology.

The problem is that the logic of industrialism does not explain why it took the form it did. Why did Great Britain and Australia, countries in which St. John Ambulance and the Red Cross both existed, not opt for the exact same solution as Canada? In Great Britain the blood system is run by the government and the Red Cross is primarily involved in disaster relief.[253] The Australian situation is similar to Canada in that the Red Cross does run the blood system, but the Red Cross is far stronger in the first aid field and even runs some volunteer squads similar to the St. John Ambulance Brigade.[254] To date, research has not turned up any reference to an agreement between the two organizations in either country.

The Political Culture Theory helps to explain the above problem. Armstrong and Nelles have stated that the Canadian solution of dealing with new technology is a result of its "distinctive economic and political setting".[255] The same can be said about its approach to social programs. Canada opted for a state sponsored monopoly of the blood system and first aid. A similar approach occurred in Australia, another parliamentary federation with a British judicial tradition. The differences in the first aid side can be explained by the fact that St. John Ambulance was not as strong in Australia as it was in Canada.

The state-centred approach is the one that comes the closest to explaining why the agreement took place. The government is clearly instigator in this program. Without its

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[253] Stanbury, *Origin, Development and Future*, p. 33 & Toby Spry, Interview, March 27, 1994.

[254] Toby Spry, Interview, March 27, 1994.

[255] Armstrong & Nelles, p. 322.

desire to achieve efficiency in Civil Defence, it is doubtful that the Red Cross and St. John Ambulance would have worked out an agreement. At the very least, the negotiations would have taken a great deal longer. But to see the government's desire as the sole reason for this agreement relegates both St. John Ambulance and the Red Cross to wanting nothing more than to please the senior authorities. From the sources, it is clear that this was not so. Also this approach grants the federal government far too much forethought in this matter. Clearly Ottawa had no idea what the long term implications of this agreement would be.

So the question remains, why the agreement? What we have here then is a very complicated situation that has in essence three sides to it: the Canadian government, St. John Ambulance, and, the Red Cross. The other players, namely the provincial governments, the hospitals and the medical profession, were not directly involved in the negotiation of this agreement. While they would be affected by it, they are for all intents and purposes in the background in relation to this agreement.

The Red Cross wanted government approval for the blood system (perhaps to help it deal with problems like the one that was occurring in Toronto). It also wanted St. John out of blood grouping, a practice it considered was more likely to produce errors and take donors away from its clinics. The reality was that it also took some of the funding away from the Red Cross. With the agreement it lost a very small part of its operations and gained federal endorsement for its program.

St. John Ambulance, for its part, wanted the Red Cross out of the industrial first aid field. The organization felt that it was here that its post-war future lay. Industry was willing to pay for first aid training, ergo it was a lucrative field if one was the only player. St. John

had also begun to recognize on its own that the blood grouping, which was taking up an ever increasing amount of its time, might actually be harmful rather then helpful. So giving this up was not that great a sacrifice. St. John usually only asked the sponsors of blood grouping clinics to cover the costs. It was not a fundraising exercise. Any loss of funding would more than be made up by the gain from the Civil Defence training for the Government and industry. The women that were displaced from this activity were found other roles, roles that would, in time, prove to be equally as important and challenging, if not more.

On the Canadian government's side was its desire for civil defence efficiency in both the blood system and in first aid. There was also the fact that Ottawa wanted to spend as little as possible to achieve those efficiencies, to avert conflict with the provinces, and appear to be introducing social reform. Was it political brokerage or pure ad hockery? Upon close examination, the answer is a bit of both. The government had a problem. It wanted efficiency in the health care field, but any overt public move to do so would have opened a constitutional hornet's nest, as had the Marsh and Heagarty reports at the end of WWII. The agreement was between two private organizations. If any criticism was raised, the government could simply point out that it had done nothing but facilitate the agreement. Ottawa also had the added bonus of not needing to provide any direct funding to these two organizations to achieve its aims.

Each of these groups brought its respective agendas to the table. Clearly, they wanted to help Canadian society, but they also wanted to help themselves as well. Had their agendas been different, it is possible that the agreement would have been different in form, if it had occurred at all. What is clear though, is that this agreement had long term and far-reaching

consequences that Canadians are still dealing with today.

Appendix A: 1951 Canadian Red Cross - St. John Ambulance Agreement[256]

this agreement made this 26th day of January, 1951

between:

THE CANADIAN RED CROSS SOCIETY
(hereinafter referred to as "Red Cross")
THE PARTY OF THE FIRST PART

and

THE PRIORY IN CANADA OF THE GRAND PRIORY IN THE BRITISH REALM OF THE VENERABLE ORDER OF THE HOSPITAL OF ST. JOHN OF JERUSALEM
(hereinafter referred to as "St. John")
THE PARTY OF THE SECOND PART

WHEREAS Red Cross is a corporation incorporated by Act of the Parliament of Canada being 8-9 Edward VII 1909, Cap. 68 and amendments thereto, and is part of International Red Cross having obligations and privileges under the Geneva Conventions to which Canada has subscribed, and carries on its work in conformity with general policies established by the International Red Cross Conferences:

AND WHEREAS in addition to being an auxiliary to the medical and welfare services of the armed forces in time of war, Red Cross carries on work all times for the alleviation of human suffering such as disaster services, blood transfusion services, outpost hospitals, activities in the hospital and welfare field, (particularly in veterans' institutions), junior Red Cross programmes in schools, nursing services and first aid services;

AND WHEREAS St. John is a corporation incorporated by Act of the Parliament of Canada 4-5 George V 1914, Chapter 145 and is part of the Most Venerable Order of the Hospital of St. John of Jerusalem having obligations and privileges under the Charter and States of the Order and carries on its work in conformity with the general policies established by the Order.

AND WHEREAS the objects and purposes of St. John are the encouragement and promotion of all works of humanity and charity for the relief of persons in sickness, distress, suffering and danger; the training and maintaining of a body of men and women throughly efficient in first aid and auxiliary nursing, the rendering of aid to the sick and wounded in war; and the promotion of such permanent organization during the time of peace as may be available

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[256] MacLaren, Appendix 2.

in time of emergency, including technical reserves for the Medical Services of the Crown.

AND WHEREAS that parties hereto are desirous of attaining the fullest possible co-operation one with the other in their similar fields of activity, in order to avoid duplication of effort and to supply the services rendered by the parties in a manner most convenient and most suitable to individual needs and with the utmost economy and efficiency.

AND WHEREAS in order to accomplish their objects , the parties have heretofore constituted a joint committee known as the "National Joint Technical Committee", which committee has made a survey of the activities concerned, and has reported thereon and the parties hereto have now agreed in manner following, that is to say:-

1. A joint standing committee shall be constituted consisting of seven persons. Three of the number shall be appointed by each of the parties hereto and a Chairman shall be appointed who will acceptable to both organizations. Such committee will deal with the operation of policies as determined by the two organizations. No person in receipt of a salary or honorarium from either organization may be an active member of the committee, but any person or persons may be invited to attend meetings in an advisory or consultative capacity. This committee will be known as the National Joint Operational Committee and shall meet from time to time as the necessity for consultation on matters of mutual concern appears to indicate.

2. Both organizations will initiate a programme of continued joint publicity to the end that the public may be kept fully informed of the work of the Joint Operational Committee in the co-ordination of effort and the avoidance of over-lapping of activities in the interest of the public, it being agreed that joint publicity should emphasize the great field for health work in Canada and that to cover it both organizations are needed. Such joint publicity shall include:-

(a) A joint statement to be sent to all daily and weekly newspapers with a request for publication;

(b) A similar statement in more detailed form, including a summary of the provisions of this agreement, the same to be printed as pamphlets for distribution by both organizations.

It is agreed that either party may publish all jointly approved material whenever deemed advisable and that the publicity of both will advertise their co-operative effort.

<u>First Aid</u>

3. St. John shall be responsible: - - -

(a) For the teaching of First Aid in industry, including basic industry in the far north such as mining and lumbering, Red Cross recognizing this field as being the

prerogative of St. John,

(b) For the training in First Aid of municipal uniformed employees such as police, firemen, etc. which field Red Cross undertakes not to enter.

4. St. John will provide certificated courses of training in First Aid to juniors under the age of sixteen years and Red Cross will not enter this field, provided, however that this restriction on Red Cross does not apply to non-certificated teaching of First Aid and accident prevention incidental to the health programme of the Canadian Junior Red Cross operating through the Schools.

5. St. John will continue to operate First Aid posts and patrols at public gatherings; Red Cross recognizing this field as the prerogative of St. John.

6. St. John will continue to operate First Aid posts and ski patrols which activity Red Cross undertakes not to enter, provided, however, that the parties may continue their present arrangements for first aid training for persons working in the Amateur Ski Patrol System. A representative of each party, together with a representative of the Amateur Ski Patrol System, shall meet from time to time to further co-operation of all three organizations in this field of special training.

7. That in such areas where satisfactory arrangements can be made by the Provincial bodies of the parties hereto, Highway First Aid Posts will be operated jointly, each organization sharing equally in the operating costs of such joint posts as well as in the provision of training and of technical supervision. The National Joint Operational Committee will endeavour to institute the use of standard or semi-standard highway signs across Canada bearing the insignia of the participating organizations. It is also agreed that the parties are favourable to the setting up of a Provincial Joint Operational Committee in any province where the joint programme is instituted, such Committee to undertake the following duties:--

(a) To give technical supervision on all matters, including the staffing of these posts;

(b) To make decisions on the servicing of areas within the province where one or other of the two organizations is already operating - i.e., allocation of responsibility to one or other organization;

(c) To interest, through their respective Provincial organizations, governments, motor leagues and other associations in sharing the costs and/or provision of facilities;

(d) To allocate the expense of operation on an equal basis to the co-operating organizations;

(e) To report at stated intervals to the National Joint Operational Committee.

8. That although training in First Aid for the Armed Forces must, of necessity be left to the decision of the D.G.M.S. of the force concerned, it is understood that both organizations are free to accept an official invitation to provide First Aid training therein and are also free to accept an official invitation to provide First Aid training in an Cadet Corps.

9. Red Cross will provide training in First Aid for the Canadian Red Cross Corps and for such other members of Red Cross as it may consider necessary to carry out its Disaster Services programme.

10. The parties recognize that in the remaining broad field of First Aid there is a great scope for endeavour for both of them, and that discussions on this subject should take place at meetings of the National Joint Operational Committee with a view to working out further agreement in this field. Pending the negotiations for such further agreement, Red Cross will not publicize First Aid classes for the general public.

11. Nothing in the First Aid part of this agreement applies to the Swimming and Water Safety Programme of the Red Cross.

NURSING SERVICES

12. The parties recognize there is great scope for their combined efforts in the nursing services field in view of the great need for training in elementary nursing techniques in the home; and , inasmuch as St. John provides standardized courses in Home Nursing and Child Welfare, leading to certification, and, inasmuch as the training given by Red Cross is designed to meet specific community needs and is more flexible, the parties agree that confusion in the public mind can best be avoided by adequate joint publicity clearly defining the role of each.

13. Information regarding courses in elementary nursing techniques will be made available by each party to the other in all districts in order that there may be complete co-operation in providing the public with the most suitable type of training for any particular group or any particular community.

14. Red Cross undertakes to discourage the advertising of Red Cross "Home Nursing" classes in urban areas, it being understood and agreed that in rural areas, publicity by the Red Cross with reference to organized classes may be necessary.

SUSPENDED in 1952

15. St. John recognized the organization and operation of sick room supply services for private homes as a prerogative of Red Cross and undertakes not to enter this field except on assurance from Red Cross that it does not wish to operate in the area concerned. St. John will not publicize sick room supply services which it may operate, except on a purely local basis.

BLOOD TRANSFUSION SERVICES

16. St. John recognizes free blood transfusion service as being a prerogative of Red Cross and agrees to: -

(a) Lend its full support thereto; and,

(b) Receded from the blood grouping and Rh typing field as soon as Red Cross advances its blood transfusion service, and, as soon as a contact is made between Red Cross and one or more hospitals in any community and Red Cross commences operations thereunder, to discontinue this activity in the area concerned.

17. By means of joint publicity, suitable recognition will be given to volunteers of St. John who have provided a valuable interim service to the medical profession and the hospitals in this field.

18. St. John will encourage its members to participate in the Red Cross blood transfusion service, both in its clinics and in the enrolment of donors, and will do its utmost, within its means, to ensure the success of this Red Cross activity. St. John volunteers shall wear their own uniforms while serving in such capacities.

TERMINATION

19. Subject as hereinafter mentioned, this agreement shall be reviewed after twelve months from the date hereof, and yearly thereafter and such amendments as agreed upon adopted, provided however, that either party may terminate this agreement at any time by giving to the other party at least six months' notice in this agreement shall prevent either party from discharging its obligations under its Act of Incorporation or under the Geneva Conventions or under the Charter of Statutes of the Order of St. John or any other conventions or treaties ratified by Canada.

IN WITNESS WHEREOF the parties have executed this agreement, the day and year first above written.

In the presence of:

The Canadian Red Cross Society
Paul Vaillancourt
L.A. Winter

For the Order of St. John
C.A. Gray
Thomas Guerin

Appendix B Selected Clauses of the Agreement between the Red Cross and a Canadian Hospital[257]

Clause 7: In consideration of the above services, the Hospital agrees to make no service charge to any person for a transfusion administered with whole blood, dried plasma (or serum) or with equipment supplied by the society. The term "service charge", as applicable to this Agreement, shall not include any fee for operating room, trays, laboratory examinations, nursing, technical and/or medical attention any other charge whatsoever directly or indirectly concerned with the administration of the transfusion.

Clause 8: The hospital agrees to supply, at its own expense refrigerator(s) of a type approved by the society and in good operating condition, suitable for the storage of whole blood, and furthermore agrees to be responsible for the maintenance of such refrigerator(s)

Clause 9: Requires the Hospital to store the whole blood under proper conditions and to make all the facilities available for inspection by the officers of the society.

Clause 10: Requires the Hospital to maintain the fluids and equipment and to take the necessary steps to avoid wasteful usage

Clause 14: The Hospital agrees, in co-operation with the Society, to make known to its patients, their friends and relatives and to its patients, their friends and relatives and to its subscribers the fact that the blood and plasma used in the Hospital are the gifts of volunteer donor through the Canadian Red Cross Society and further more agrees that all its accounts submitted for hospitalization and/or treatment shall bear the following legend:

> "A free blood transfusion service in this Hospital is supplied by the Canadian Red Cross Society in co-operation with the Provincial Government and the hospitals of . . ."

Clause 15: The hospital agrees, unless specifically agreed by the Society's Provincial Medical Director to the contrary, that the Society shall be its sole source of supply for whole blood, plasma (or serum) and sterile equipment used for the transfusion of both its private and public ward patients. The Hospital furthermore agrees that it will not issue whole blood, plasma (or serum) or sterile transfusion equipment for use outside its own hospital without specific authority from the society

Clause 16: The Hospital agrees that where the grouping of a patient and or the direct matching of whole blood prior to transfusion is not performed at all or is

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[257] Model contract between a Hospital and the Red Cross, from the CRC Archives

undertaken by an employee of the Hospital, a medical practitioner, nurse or laboratory technician other than one regularly employed by the Society, the Society shall not be held liable for death or injury of the said patient when such death or injury is attributed to transfusion, not withstanding that the blood employed for the said transfusion has been supplied by the society

Clause 17: The Hospital agrees that where a transfusion of whole blood or plasma (or serum) is performed with equipment other that the sterile units provide by the society for this purpose, or where such transfusion is immediately preceded, accompanied or immediately followed by the injection of any substance other than the products supplied by the Society, the Society shall not be held liable for the death or injury of the patient, where such death or injury of the patient, where such death or injury is attributed to the transfusion, unless error and/or negligence on the part of the Society's officers in the grouping and direct matching of blood samples submitted for this purpose to the society by the Hospital are shown to be the cause of such death or injury, not withstanding that the blood or blood product employed for such transfusion has been supplied by the Society."

Clause 18: The hospital agrees that where the transfusion technique employed is other than that prescribed by the Society or by recognized medical practice, the Society shall not be held liable for death or injury is attributed to the transfusion, not withstanding that the blood or blood product employed for such transfusion has been supplied by the society.

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