In recent years, much has been written about the failure of modern public health nursing to reach its historically much glorified potential. The profession of nursing itself is suffering from what Susan Reverby has called a “disorder” spawned by the uneasy hospital-nursing relationship initiated over a century ago. Fleeing this hospital bond, nurses who began a career in public health nursing were hoping for autonomy, independence and a chance to use their skills in a new way—to prevent illness, rather than heal it.

As Beverly Boutilier’s paper in this volume points out, the historical beginnings of public health nursing reveal its class-conscious roots, both in terms of who should constitute the client, and who the nurse. Boutilier’s discussion of the evangelical women (not trained nurses) who were members of such societies as the Order of King’s Daughters and the Toronto Nursing-at-Home Mission, reveals that they believed that any respectable woman called to God’s service could nurse among the poor. In like fashion, district or visiting nursing, which originated in England in the mid-nineteenth century, was a form of charity for the sick poor at home.

Although dissimilar in structure, visiting or public health nursing organizations in the Anglo-North American world shared many values and assumptions about the work and moulded their service to suit their own contexts. However, each stressed the importance of cleanliness, morality and compliance to the middle- and upper-class values of its lady patrons, who were often either titled (in the case of England and Canada), wealthy or both. Each endeavoured, with varying success, to recruit nurses who had the requisite “gentlewoman” qualities to reform and teach those they visited. Florence Nightingale’s model, incorporating environmentalism, sanitary reform, and a rigid class structure, largely dictated the way district nursing was practised in the English-
speaking world from the 1860s until the turn of the century. Her values reflected widely accepted Victorian views of health, disease and class relationships.3

This paper reports on one aspect of a larger historical analysis of public health nursing in rural Ontario, which examined the daily work of a group of public health nurses and their relationships with families, women's organizations, politicians, and physicians in small rural communities.4 The Ontario Provincial Board of Health's child welfare demonstration project of the 1920s provides the context for the analysis. In 1919, the Board received funds from the legislature to send sixteen nurses across the province, hoping to decrease childhood mortality and morbidity in small towns, and in rural and northern Ontario where new immigrants and the poor predominated. Typically, our knowledge about such projects has been from the "top down"—from the perspective of the policy makers—rather than from the central actors themselves. In this instance, a great deal of rich, day-to-day documentary evidence, as well as oral testimony, and annual reports,5 exist to provide a more realistic description of actual, everyday work. My central concern was the way in which the particular conformations of gender and class informed decisions about rural public health work and what this revealed about the deployment of power in contemporary society.

I want to explore the sometimes conflicted and often ambiguous relationships between the nurses—all female—and two kinds of male physicians: their "superiors" at the Board of Health and the local, small-town general practitioners. I want to begin to answer the following complex questions: How was gender a primary field within which power over decision making was articulated? How did the nurses both transform the external constraints on their work and yet reinforce the dominance of medical authority?

I will argue that the extent of responsibility that public health nurses shouldered for the success or failure of the child welfare project precluded a passive and subordinate stance. On the one hand, they were often hundreds of miles away from a physician and were required to substitute for physicians as the need arose. On the other hand, their tacit acceptance of the professional protocol that warned against "diagnosis, prescription or treatment" meant that they deferred to physicians, or covertly used strategies to get around the rules. This was the difficult, sometimes impossible, situation in which the nurses found themselves. One anonymous Victorian Order Nurse in Canada's frontier West justified her work in this way: "The nurse is not supposed to take a medical man's place," but "half a loaf is better than no bread."6
The Victorian Order of Nurses

Since the organization of trained nursing and well into the twentieth century, nurses have acquiesced to being subordinate to physicians’ authority over patient care and over themselves in relation to the medical care of patients. But, as historian Joan Lynaugh has concluded, "nurses tried to draw a distinction between authority over patient care and authority over themselves as persons" (emphasis mine). Unfortunately, their “acceptance of the military metaphor complicated and compromised that distinction.”

They were expected to obey the physician and be loyal to him, almost without question, since he was the “captain of the ship.” Isabel Hampton’s characterization of the nurse as “the physician’s lieutenant” preceded the following passage from her influential speech to the 1893 World’s Fair assembly, and was typical of the way in which the practice of nursing was viewed:

The hands of a nurse are the physician’s hands lengthened out to minister to the sick. Her watchful presence at the bedside is a trained vigilance supplementing and perfecting his watchful care; her knowledge of his patient’s condition an essential element in the diagnosis of disease; her management of the patient, the practical side of medical science.

Much of nursing’s dependence on the professional authority of physicians lay in the fact that most nurses trained in hospitals where, by 1900, physicians were the acknowledged heads. When the nurse graduated to the uncertain world of private duty, she depended upon the good will of physicians to refer cases to her. When Canadian visiting (or district) nursing began at the end of the nineteenth century with the Victorian Order of Nurses (VON), a distance was created between the nurse and the physician, which theoretically allowed the nurse more autonomy and control because she almost never saw him. And, since she often visited the poor, she avoided much of the physician’s concern over competition for fees. However, working with the middle classes was a different matter: they had a small amount of money that might be used for the physician’s care, rather than the nurse’s.

As Boutilier’s paper demonstrates, Lady Ishbel Aberdeen, the dynamic wife of the Queen’s representative in Canada, encountered trouble when she first attempted to raise funds to support the VON in the late 1890s. Doctors in every major city and town were almost uniformly against the venture, and wealthy, influential people had
refused to support it when physician hostility was so high. Lady Aberdeen recalled that in early 1897:

Rumours had gone abroad that the Victorian Nurses were only to be partially trained, and secondly, that they were to act independently of doctors in country districts, and were thus likely to be employed in the place of medical men because of their lower fees. . . .

Fund-raising was so difficult that the Governor-General, Lord Aberdeen, paid the first superintendent’s annual salary himself for two years; this was the only way to start the venture.

The opposition by physicians was finally quelled by an American medical man, Dr. Alfred Worchester, the controversial founder of the Waltham School for District Nurses in Massachusetts. Lady Aberdeen had visited Waltham several times seeking advice from the school, and had followed its program with interest, in part because no one in Canada seemed suitable to be the lady superintendent of this promising, new organization. (Indeed, the first three superintendents, who were Canadian by birth, came from Waltham.) In 1897, Aberdeen persuaded Worchester to come to Toronto and Ottawa to “convert” Canadian physicians to the idea of district nursing. The meetings were successful: he provided information, as well as “what physicians like to eat, smoke and drink at ten o’clock of the evening.” By December 1897, the doctors in Toronto and Ottawa had agreed that visiting nursing should go ahead. After all, Worchester urged, the nurses were “trained to know their own proper sphere . . . they know too much to interfere with the physicians.” And if they did interfere, they would be “very quickly discharged by the rules of the Order.”

Lady Aberdeen’s problems with Canadian physicians, and the subsequent silencing of opposition, revealed the subtle ways in which gender and class were important variables in the articulation of power. Aberdeen found it necessary to utilize an elite American medical man who knew the “language” and habits of his fellow physicians, and how to win them over. It is unlikely that they would have acquiesced to anyone but a male physician, given the prevailing attitudes toward female authority and the necessary subordination of nurses. This pattern would continue into the twentieth century as many physicians continued to find it difficult to accept a female nurse’s authority in matters of child welfare and public health organization.
The “New” Public Health

Allopathic (or regular) physicians in both Upper and Lower Canada established medical licensing boards as early as 1790. By 1868, the Canadian Medical Association had adopted its inaugural Code of Ethics, which “combined points of moral concern with monopolistic and paternalistic injunctions designed to assist the regular profession both in its specific struggle to discredit irregular practitioners and in its general attempts to improve upon . . . the privileged socioeconomic position of regular practitioners.” Professional associations in Canada developed in concert with licensure and with tightly controlled numbers of medical schools, which were always associated with universities.  

By 1900, physicians had ensured their control over hospitals, and were sending their patients there. They also moved to dominate the field of public health. Indeed, the central theme in the history of late nineteenth and early twentieth century public health is the hegemony of medicine and science over the voluntary pietistic reform movements that dominated earlier efforts. However, there was no sudden takeover. Rather, gradual change softened by shared social values and the appropriation, or “medicalization,” of many reform ideas characterized the period. The perspectives of the physicians and scientists on the Ontario Board were typical of many in North America who embraced the so-called “new public health movement.”

The new public health movement was essentially characterized by the rise of modern professional workers: public health physicians and nurses, sanitary engineers, bacteriologists, vital statisticians and epidemiologists. Physicians tended to dominate since many bacteriologists and epidemiologists were medical doctors who had received special training in the United States and Europe. Indeed, specialization in medicine was expanding into many areas. For example, pediatricians and obstetricians were added as consultants to boards of health everywhere. When the causes of many of the diseases that scourged the population were discovered in the 1880s, reformers began to see illnesses as specific clinical entities with unique courses and pathologies. Thus, by 1890, scientists and physicians were beginning to see disease as preventable. However, cleanliness was still important, although for different reasons than people previously believed. According to one prominent reformer, Dr. Hibbert Winslow Hill:

The modern public health man cares nothing, so far as restriction of disease and death is concerned, for the dirty back yard or the damp
cellar in themselves, but only as they may enter into the transmission of infected discharges. Then, at once they become of vital importance.\textsuperscript{14}

In this new preventive work, the special ability of one woman to reach another was a powerful incentive to using nurses, almost always female, rather than the medical officers of health, who were always male. It was believed that the compassionate, caring "nature" of the nurse was much more suited to the teaching functions involved in child hygiene, and that the physician's realm was the technical, decision-making, administrative aspect of public health work. And the nurse was practical: in the home she could work with the mother's own facilities and show "how necessary things can be done." Later, she could return to supervise, safe in the knowledge that she had the mother's trust.\textsuperscript{15}

Another equally important reason for using nurses rather than physicians or sanitary inspectors in a "child-saving" project was the relatively low cost of a nurse's salary compared to that of the district or city medical officer. In 1919, the year before the demonstration began, the Toronto board was clear about the advantages of using a nurse for some aspects of the work:

Because a doctor costs about twice as much as a nurse, it is the policy of the department to have the public health nurse do as much work as she can thus making it possible for the public health physician to spend all of his valuable time doing only those things that demand this special skill and training.\textsuperscript{16}

Indeed, in Fort William, "the visiting nurse," Miss Fisher reported in 1916 that she had been able to accomplish much in the "coal-dock section" at a cost of eighteen cents per visit. One reformer stated that it was clear that it had been the "personal supervision, personal interest, personal teaching by an expert (a doctor or a nurse)" that had lowered the death rate of infants in Fort William by thirty-three percent from 1910 to 1911: none of the babies who had died there had been breast-fed. It is not surprising that in North Bay the medical officer argued that "big dividends would be returned on a small outlay" if nurses were used to save babies and children.\textsuperscript{17}

Control of Nurses' Work

On 5 March 1917, Hill was a key figure in a meeting of the Board called to consider the question of hiring public health nurses to educate
mothers about child care. It was an important meeting. All of the physician Board members were present, as well as Dr. John G. Fitzgerald, director of the Connaught Laboratories; the directors of the Branch Laboratories (all male physicians); the Provincial Chemist; three District Officers of Health; the Provincial Statistician; the Chief Sanitary Engineer and the Provincial Secretary, Mr. McPherson. Dr. John McCullough, the Chief Medical Officer of Health, was in the Chair. Miss Mary Power, the non-physician Director of the Child Welfare Bureau from 1916 until 1925, was the sole woman present and was referred to as "our friend." Miss Knox, the nurse-in-charge, who had been travelling around the province with the Child Welfare display, was absent.¹⁸

The physicians clearly dominated the meeting and the decision making.¹⁹ Hill, Fitzgerald and McCullough controlled much of the discussion due to their status within the group and Hill's previous experience with rural demonstrations in Minnesota. The non-physicians such as Mr. Lancaster, the Provincial Chemist, apologized for "not being a medical man" and seeing things "only from a chemist's viewpoint." Power and Hill clashed over the function of the nurses: she understood that they were to be general public health nurses, while he believed that they should only be involved with infant mortality work, not getting mixed up with "all the old squabbles and quarrels about sanitation." McCullough immediately agreed with Hill and a motion was passed, delineating the nurses' role as involving childhood mortality.²⁰

Although the members spent considerable time debating such questions as how to increase birth registrations, very little time was spent in discussing to whom the nurses would report, and who would have direct authority over them. Even the question of their legal status within the communities went unanswered. Power and Knox had some administrative control, but who would really direct their work in the towns and villages? Would they be left to their own initiative?

Dr. Maloney, the Health Officer in District Five, was concerned about this. He wanted control over the nurses' activities and predicted problems if this was not to be the case. As he put it:

It looks to me as if you are going to have a little friction with the district officer. If you are going to have a nurse going here and there in our districts over whom we have no control, we are going to have friction. I think the matter should be so arranged that the nurse should work in cooperation with the district officer, that is, as to where she shall go and what she shall do, and in the meantime she should specialize in this
office as to the particular work she shall take up under the direction of
the district officer. 21

McCullough agreed that the nurse "ought to be somewhat under
the district officer of health" and that the two groups should be "in
harmony." One of the Board members, Dr. Kaiser, put it more forcefully,
saying "she ought to report to him and he should report to you." 22
Regarding the local, private physicians and any potential conflict with
them, McCullough was clear in stating, "I do not want the nurse to be a
doctor; I do not want to have her come into conflict with the doctor."
Power was quick to reply that the nurse "would never do diagnostic
work." However, the matter of who would have day-to-day authority over
the nurses was never to be finally decided in the meeting and would
cause problems for them in the future.

Rules of Professional Etiquette

After the nurses had begun their work, the "regulations" included
admonition concerning the relationship of the nurse to the physician.
The nurse was cautioned to suggest "absolutely no treatment or diag-
nosis," nor to advance "opinions." Family physicians were to be notified
"in writing" after the nurse made her first visit to a patient and future
visits were to be deferred for two weeks "pending his reply." If a physi-
cian objected to the visits, "they [were to] cease immediately." The nurse
was required to send a report of each visit to the physician as soon as
possible. Furthermore, nurses were advised never to recommend a
physician and to always "explain the importance of regular visits to the
doctor, and careful attention to his instructions." Any instructions from
family physicians to the nurse were to be carried out without fail.

Instructions about the conduct of a "well-baby clinic" also
included statements about the advice "the public health nurse attending
at a clinic may properly give" to mothers, and about the way she was to
assist the physician "any way she as a nurse can." In addition, all the
nurses' records were to be available to "the medical attendant." 24 Such
vague directives were all the nurses had to guide them and only
certained to the clinic situation when the physician was present. What
was the nurse to do when she came upon a sick patient or a community
whose survival depended upon her medical diagnosis? Teaching preven-
tative measures to mothers was all well and good, but when people were
sick and could not (or would not) consult a physician, what was the
nurse to do?
Contemporary public health nursing textbooks carefully admonished readers against trespassing onto the physician’s territory. For example, Mary Gardner’s eight principles of public health nursing, assigned to the nurses by the Toronto public health nursing supervisor Eunice Dyke for the purposes of class discussion during their three-month educational preparation, prescribed “rules” of appropriate behaviour for the public health nurse. These principles were adopted as fundamental because they were felt to be of vital importance to the nurse who would be out in her district, away from her supervisors. According to Gardner, one of the early leaders of American public health nursing, appropriate behaviour according to the principles included avoidance of giving “material relief” to patients; shunning interference with the patient’s religious views; the necessity to co-operate with other social agencies—that is, not to “play her own game”; the importance of keeping “suitable and accurate records”; the insistence that “patients unable to pay for nursing care should receive free service, and that those able to pay for it should do so according to their means”; regulation of hours of work for the nurse; and, finally, rigid observance of “professional etiquette” in relations between physicians and nurses.

Acknowledging that “public health nursing has had in the medical profession its greatest friend, and not infrequently its greatest stumbling block,” Gardner insisted that it was necessary to win over “former opponents” in order to ensure the co-operation of all physicians and, thus, the continued development of public health nursing. If nurses followed the “rules” of professional etiquette, the support of physicians would be assured.

Acknowledging that disregarding her own judgment about a patient’s care could be difficult for the nurse—not to mention dangerous for the patient—Gardner nevertheless believed that this dissonance could not be resolved by breaking the rules, but rather “by the gradual education of public opinion to the point where the importance of baby work is understood.” In other words, it was the responsibility of the patient and family to understand “good” versus “bad” care. Unfortunately, leaders such as Gardner wished to avoid conflict with physicians more than they wished to help public health nurses deal with the problems that would inevitably come when nurses were more independent of physicians than they had been in the hospital milieu.

For public health nurse Marguerite Carr-Harris, the rules about physician-nurse conduct provided a structure for teaching future mothers the sexual division of labour in the health care system. In her Little Mother’s League classes, she demonstrated to nine- and ten-year-
old girls how thoroughly she was indoctrinated with the expected role behaviours of the mother, doctor and nurse. Wishing to teach them "why babies die" and the "signs of a sick baby," she first read them a lesson on signs of sickness and then divided the group into mothers with sick babies, mothers with well babies and public health nurses. Carr-Harris herself, role-playing the "doctor," called on each mother inquiring how the baby was and then "the doctor left a public health nurse behind to instruct her as to why babies die and what she must do if baby becomes ill." Not surprisingly, Carr-Harris reported that the "little mothers entered wholeheartedly and seriously" into the game. This anecdote was reported in the nurses' Bulletin as an example to other nurses of a good teaching strategy for girls who would one day be mothers.28

Experiences of Shifting Boundaries in the Field

Although it was clear that nurses were to do something different from the physician, always supporting and reinforcing his directives to the mothers, the boundaries were often blurred and shifting, particularly when no physician was available or when the nurse encountered serious illness that needed immediate attention. In some instances, the nurse was sure that she knew more about a case and how to treat it than the physician. In the small towns and villages, many physicians were out-of-date and unfamiliar with the new prevention and treatment modalities that the nurses had learned from elite, urban medical specialists. Some physicians wished to learn from the nurses and co-operate with them. Others were hostile and unco-operative, or simply indifferent.29

One incident revealed the kind of medical ignorance and indifference that the nurses encountered in managing communicable disease and its prevention. In 1923, Carr-Harris found that whooping cough was epidemic in the isolated Tait and Mather townships of Rainy River District. As she put it, "nearly every family in this back country seemed to be in some stage of it." This is what Carr-Harris did:

We advised those with babies who had not yet become infected or were in the early stages, to take them to their doctor for preventive treatments as we knew one Emo doctor had been giving serum for whooping cough on the occasion of the unveiling of the Barwick Monument. The Post Master at Blackhawk accordingly drove in 25 miles to Emo, and his own doctor, happening to be the other man, said he did not think that
anything could be done. The whole family later had the disease and the baby very severely. 30

This incident occurred almost ten years after the Board made serum available, free of charge, to any physician requesting it.

Public health nurse Marjorie Heeley recalled a number of incidents of conflict with physicians and confusion of roles. In Parry Sound in 1923, she had a “set-to with a young doctor” after she gave him some information that she had gathered. He “resented . . . resented” her giving him any information and gave her a calling-down. She could not understand how her action was infringing on his territory, although she was certain he perceived that it had. He later put her on an overloaded boat back to the mainland, an action that put her in some danger and made her feel that he was angry and wished her ill. In Englehart, there were two doctors, one was drunk all the time (although he was a good doctor), and the other, who was young, didn’t know anything about child care. He would ask her, “What would you do?” and left a lot of responsibility to her. For example, he didn’t know what to do if a baby had dysentery. 31

Responsibility for the lives of her patients, often babies, weighed heavily on her when she feared the physicians weren’t “up to date” or when there was no physician, either because of distance or poverty. Sometimes she questioned whether she had done the right thing to send a patient to the doctor in these situations, either because she knew they wouldn’t go or because she did not trust the physician’s knowledge. She remembered going up to a mother on the street and seeing that the baby in the pram was very ill, and that the mother did not realize it. She told the mother to go to the doctor right away, but the baby died, either because the mother did not go or went too late.

In Whitney, where there were no doctors, she found a sick child and got orders from a doctor over the telephone to give the child some medication. The child died, and this is the way that Heeley expressed her feelings of guilt and confusion over what she should have done:

Whatever he told me to give that child . . . killed it, and he wasn’t there, you see . . . it died. I don’t know whether it was an injection or what, I forget. It was old medicine and it was too strong . . . that’s what I felt afterwards. It was practically poisoned . . . instead of being helped. If I’d done it my way . . . I wouldn’t have, you know . . . if I’d done it alone, on my own, I think I could have saved that child. But because I got the doctor. . . . 32
Although she did not remember exactly what she would have done, the strong impression remained that she could have done better on her own, without the doctor. However, her professional training and the rules of the Board told her that she must call the doctor, even though he practised old medicine. On the other hand, there were times when she was called to homes and did the best she could, knowing that she was the only medical person available and yet feeling totally inadequate for the job. This was especially true of maternity cases: she remembered a baby being born very prematurely to a mother with five other children; by the time she could look at the baby, it had hemorrhaged and died. She knew that she did not have the knowledge nor the equipment to save the child, and resolved her grief by doing the best she could and going on to the next case. However, the feeling that one had to be ready for anything stayed with her.\footnote{33}

What many physicians (and some nurses) apparently did not understand was the difference between nursing care and medical care. Board consultants had prepared the nurses with the newest ideas in the primary and secondary prevention of childhood and communicable diseases. They should not have presented a threat to physicians, who were skilled in the diagnosis and treatment of disease. Heeley recalled very clearly that what the mothers needed was “nursing care, not doctor care.” There were many things that mothers did not know about feeding and caring for their children that the doctor was not prepared to teach, nor did he have the time. “It was education they needed” and the physicians “hadn’t been trained about childcare” in the way the nurses had been. Besides, in the home, the nurse could see things that the mother was doing that were “inadequate”; the doctor would never see these problems since people wouldn’t call him unless the baby was already sick, and no home remedy had worked.\footnote{34}

In teaching preventive measures, the nurses often came into conflict with physicians’ orders, especially with regard to infant feeding. Breast-feeding was acknowledged by most pediatricians and public health experts as the best prevention for infant diarrhea in the first year of life.\footnote{35} But, as Public health nurse Edna Squires wrote from the impoverished town of Arnprior in 1923, the doctors there gave lip service to the importance of breast-feeding, “but half the babies in town are on Allenbury’s and Malted Milk ordered by the doctor.” Although it was widely believed that every bottle-fed baby should be under a doctor’s care, many physicians in the rural areas were not well informed about artificial infant feeding practices. Therefore, the nurses attempted to
promote and support breast-feeding whenever they could, especially for the most high-risk (usually poor) babies.\textsuperscript{36}

In Kenora, Carr-Harris and her colleague Miss Whitworth tried to counsel a Galician mother with five other children to keep nursing her twins, although the physician, Dr. Paton, had suggested to “try one bottle a day.” Because babies were continuing to die in the town, Carr-Harris was afraid that the bottle-feeding would lead to weaning, and subsequent disaster. To complicate matters, the nurses were asked to visit sick babies who were under the care of a physician, but who were not getting better. How should the nurse act in this situation? It was obvious that some of the physicians were less informed than the nurses, so Carr-Harris received help from a pediatrician in Winnipeg, consulted Maternal and Child literature and continued to encourage breast-feeding.\textsuperscript{37}

When Carr-Harris and Whitworth attempted to organize their program in Kenora, they found that the physicians were a “stumbling block” and did not give immediate support as the other groups did. They stalled on holding a meeting to decide what assistance they would provide and Carr-Harris concluded that neither the Medical Officer of Health nor the doctors were “at all keen” on the idea of holding a baby clinic. They needed the support of one physician in particular, Dr. Gunne, who was extremely influential and worked on contract for the Canadian Pacific Railway. Carr-Harris expressed her feelings this way:

\begin{quote}
The Doctors at present are so lukewarm that we will have to go very gingerly—am hoping great things from Dr. Middleton and his power to change their attitude, for the whole future of this district hangs on making a successful beginning here—It will be most difficult to recover from any friction or upset with these doctors—we would be unable to work here and the example would be very harmful & would in fact prevent our going to any of the places over which Dr. G. presides.\textsuperscript{38}
\end{quote}

Gunne and the other physicians were indeed “won over,” largely because of the visit from Dr. Middleton, the Director of the Division of Public Health Education. In order to gain credibility for their program of action, it was necessary for many of the nurses to call in their superiors, the physicians who were employees of the Board—Dr. McCullough, Dr. Bell (the Board’s pediatrician), Dr. Middleton, and later, Dr. Phair—to convince local physicians that they should support the nurses. And the nurses had to be careful, lest their superiors thought that they were too aggressive in making suggestions, or that they did not wait for permission and direction from them.\textsuperscript{39}
Olive Gipson reported from Smith's Falls on 17 March 1921 that she was not getting any co-operation from the physicians—the response was distinctly frigid, even from the local Medical Officer of Health, who was distinctly "not with us." After Bell came to a baby clinic and explained the medical Attendant's work in great detail to the physicians, "he cleared the whole atmosphere for us." Gipson concluded that "now we hope to be able to carry on successfully." Edna Squires wrote from Alexandria on 3 July 1924 that although she saw the need for a throat specialist—and was afraid "the local men will be taking up the work" (incompetently)—she had to wait for Bell to arrange it or for the local doctors to request an outsider. On 23 January 1924, Squires had written to Power that the children desperately needed dental work and she proposed to approach the dentists about holding a clinic (at no charge). Power replied that "the dentists must organize their own clinic," and added, "you offering all assistance within your power, but undertaking no responsibility in the direction of the work, etc." Such matters needed to be carefully handled so that the nurse never appeared to be interfering as an outsider, nor inappropriately requesting specialists' help.

As might be expected, there were sometimes problems when the nurses attempted to circumvent their constraints by creative means. Squires reported from Almonte in October 1922 that the doctor's wife—a member of the Women's Institutes—had so much trouble and received so much criticism for organizing tonsil clinics that her husband was ready to divorce her. The woman blamed Squires for getting her into it. The specialist from Ottawa had charged fifty dollars per operation, the poor couldn't pay and the local doctors were annoyed that an outsider was brought in. Squires lamented: "Is it any wonder that so many people think there is something lacking in our work when it just points out the defects and then makes no provision for helping poor people get them corrected."

However, in order to be effective and feel satisfied with their work, the nurses needed to take initiative. Often, they were successful in getting across their message or in averting disaster. As Heeley put it, "you had to diagnose, you wouldn't be any good as a nurse if you didn't." For example, Squires decided to change an Alexandria baby's formula, ordered by Bell at a clinic, because it had developed diarrhea. Mothers in Kenora frequently called Carr-Harris or Whitworth to help with infant feeding problems. The nurses felt their responsibility (and inexperience) in giving advice, especially since the cow's milk supply in the town was not adequate, but how could they refuse to help?
Frequently their successes were more subtle, due to their ability to defuse hostility or convince doubters before larger problems arose. In Alexandria, Squires encountered the inspector of the public school who sent a letter to the principal stating that "as they have two doctors in their family," he did not see the need to have his child inspected by the nurse. She accepted this, recognizing that he was unfamiliar with the public health nurses' role, and allowed him to watch her examining children, spending time talking to him. His opposition vanished. In Belleville, Heeley spoke to an open meeting at City Hall about public health work. She received a letter from the Chamber of Commerce, praising her for her address. They called it "a model of lucid and forcible exposition," and complimented her on her "tactfulness . . . displayed all the way through without at the same sacrificing truth and effectiveness." 44

Often, however, the nurses were forced to work within the narrow limits that were invoked by the social processes and power relationships of gender. They had to deny their ambition and their achievements in order to be evaluated successfully by their superiors. For example, Squires wrote to Knox in 1924 that she had a suggestion about what kind of advertising should be put in the newspaper for the Alexandria Health Week, but "would rather Dr. Bell should not know that I suggested it." 45 Carr-Harris was frequently asked to address many different community groups about the Public Health Movement. Organizations such as the Women's Institutes considered her 1926 speech to their District Annual Convention sufficiently important to publish it in their Annual Report. However, before preparing this speech, she wrote to Dr. Phair, then the Director of the Division, hoping that someone "in command" would be able to come and speak. When this proved impossible, she asked to be instructed as to her message in regard to the work, writing that she wished to "strike the note which you wish struck." 46

Even their private lives were regulated in a military fashion: the nurses required permission to leave their communities for the weekend or a holiday such as Christmas; one nurse was required to stay in the district at all times, even at Christmas. They often pleaded overwork, as if they needed an excuse to get away. 47 If their presence was requested by a District Officer of Health or a Medical Officer of Health, there was no question about obeying, even if such a request interfered with their own plans. Some of the nurses, like Squires, complained privately to Knox about unreasonable demands, not wanting the physician to know. 48 Others, like Ethelda Corbman, complained openly in a letter to Power about having no part in decisions regarding her own work. Dr.
Sparks (the District Officer of Health) and McCullough had decided that she would travel to Toronto with Northern tuberculosis patients at Christmastime; it was never discussed with her, and she was opposed to the trip because she had previously made plans to stay in the North for Christmas. Complaints such as the following also revealed the lack of control and the frustration some of the nurses must have felt:

I am very short of funds and have been for some time. It is five months today since I have had expense account cheque. I have bills to pay myself that I have not been able to meet as I have had to use my salary for travelling expenses. I have had to slight my work on account of shortage of funds and have not accomplished all that I would have on account of having to return before I should have... It makes one feel rather disgusted and the work suffers.\(^49\)

Not all of the nurses were sufficiently prepared to deal with the kinds of situations in which they found themselves; these nurses left the Board’s employ. By the summer of 1922, at least two of the nurses had resigned because of the Board’s dissatisfaction with their performance. One of the nurses, Olive Gipson, did not understand why her work was unsatisfactory and believed that she was being discredited unfairly by the Board physician. In a letter written to Knox on 1 March 1922, requesting a conference with her superiors she stated:

All I want is for Dr. Bell to produce his proof of what he has reported and give me a chance to defend myself,... to me honour is the greatest asset a person possesses and I do feel that mine is involved,... I have written you very frankly but you have always urged us to do so and even at that, I have not expressed even a little of what I feel.\(^50\)

Fanny May Bagshaw became very discouraged when Northern physicians “failed” her; she admitted to wanting to give up. In late 1921, Power and Knox began to openly express in letters that they were “very much disappointed” in her reports. In the next six months, Bagshaw was berated for not obeying “orders” from head office and for not consulting the local Medical Officer of Health before she approached the council. When she asked for help in convincing local authorities of the need for a nurse, the responsibility was put entirely on her shoulders. Knox told her: “Our demonstration should clear up any doubts he [the Medical Officer of Health] has as to the usefulness and need of a community health nurse.” She had failed to get a nurse appointed in Thessalon, where she blamed the failure on her Protestantism: eighty percent of the community was Roman Catholic. She was contemptuous
of the Medical Officer of Health there who was a "little Russian Jew and very hard to deal with." In June 1922, Bagshaw was recalled from the North and she resigned in July.51

Conclusion

Conflict and contradictions were inevitable as public health nurses and physicians attempted to work together. As a result of their medical training, physicians had come to believe that they were the "captains of the ship,"shouldering total responsibility for the outcomes of patient care. The Board's Toronto physicians, particularly McCullough and Bell, both elite and well-connected socially, had legitimate authority over the nurses, who were almost all from families never considered elite. Local community physicians were geographically close, yet had little real authority and were generally reluctant to accept the nurse as an equal, socially or professionally. The nurses' "outsider," urban status undoubtedly influenced their acceptance by locals. Both groups of physicians may have seen the nurses' work as surrendered authority rather than as delegated functions, or appropriately independent actions.52

As a result of their training, nurses were likely to defer to medical authority, seeing physicians as superior in skills and knowledge. However, because they were experimenting with new self-images as health teachers and medical diagnosticians, ethical dilemmas and internal discomfort could be expected. Away from the hospital, the work of health care did not have the same well-known, rigid rules. In the community, a "no man's land" existed between medical care and nursing care. Who was the principal care provider? Who should make what decisions?

One way to handle the problem of professional boundaries has been called "the doctor-nurse game." First described in 1967 by an American psychiatrist, the cardinal rule of the game was that open disagreement must be avoided at all costs. Conflicting messages underpinned the game:

The first set of messages implies that the physician is omniscient and that any recommendation [the nurse] might make would be insulting to him and leave her open to ridicule. The second set of messages implies that she is an important asset to him, has much to contribute, and is duty-bound to make those contributions. Thus, when her good sense tells her a recommendation would be helpful to him she is not allowed
to communicate it. The way out of the bind is to use the doctor–nurse game and communicate the recommendation without appearing to do so.53

The following anecdote exposes the conflicts and contradictions inherent in the relations between nurses and physicians, suggesting that the nurses discussed problems, privately, among themselves, but never publicly. In an April 1922 personal letter to her supervisor, Miss Knox, Edna Squires inquired if Knox had heard the following "joke": A public health nurse was asked by one of her patients "if she didn't think it was nice weather." The nurse replied, "I don't know, you had better ask your physician."54 Ultimately, the joke revealed that the nurses were forbidden to have an opinion about anything; an opinion was the physician's prerogative.

The nurses were able to deal with the dilemmas imposed by their unfamiliar roles through using such passive strategies, enabling the physician to believe that the ideas were his own and thereby maintain his authority. Nurses also involved community women and men in organizing public health activities, rather than risk displaying their own ambitions publicly. As Barbara Melosh points out, on the one hand, they accepted and even reinforced medical domination of health care, because public health opened up unprecedented opportunity for nurses in the physician's absence.55 On the other, they saw that the lack of role clarity and direct communication could gravely affect people's health. However, they could only privately express resentment over their lack of control because public outcry and rebellion were not perceived as options for women in 1920s nor 1930s Ontario.

Endnotes

1. For the United States, see the articles written in Nursing Outlook 31 (November/December 1983) especially Katherine Chavigny and Mary Kroske, "Public Health Nursing in Crisis," 312-316. For historical scholarship interpreting why public health nursing "failed," see Karen Buhler-Wilkerson, "False Dawn: The Rise and Decline of Public Health Nursing, 1900–1930" (Ph.D. dissertation, University of Pennsylvania, 1984). For an account of why public health nursing declined in a Canadian city after 1925, see Kathryn McPherson, "Nurses and Nursing in Early Twentieth Century Halifax" (M.A. thesis, Dalhousie University, 1982). 75-105. For Ontario, Canada, the best evidence of dissatisfaction and powerlessness in the ranks can be found in the Newsletters of the Community Health Nurses' Interest Group of the Registered Nurses' Association of Ontario. See, for example, the winter 1986 issue in which public health nurses' "image" and "ineffective utilization" were identified in a survey of members as two of the most important issues facing the profession. The creation of a new category of public health worker, the "health
educator," is also of concern to Ontario public health nurses, who are being laid off in increasing numbers. See the spring 1993 issue of the above Newsletter, p. 19. Health educators are often male; the overwhelming majority of public health nurses are female. Male nurses work in hospital critical care and psychiatry units, for the most part.


5. These documents are in the Archives of Ontario (hereafter AO), RG 10, Series 30 and RG 62, Series F. The Provincial Board of Health Annual Reports (hereafter PBHAR) must be read with caution, since they were left partially as a record of accomplishment, seeking to place things in the best light possible. Correspondence of the nurses in the field is, of course, also suspect because they may have wanted to rationalize their own failures (and successes) to their superiors, and, undoubtedly, "filtered" much of what occurred. Typically, the population's response to the project is lacking; only one or two letters attest to some reactions. Some relevant suggestions on the latter were offered by Katherine Arnup, "Mothers and Nurses: Enemies or Allies?" (Paper presented to the First National Nursing History Conference, Charlottetown, 16 June 1998). For popular reaction to vaccination see Paul A. Bator, "The Health Reformers versus the Common Canadian: The Controversy over Compulsory Vaccination against Smallpox in Toronto and Ontario," *Ontario History* LXXV (December 1983): 348–373.


10. Gibbon, 19–23, 25. For a more detailed analysis of this conflict, see Boutilier's paper in this volume.


15. These views were expressed in the Toronto Department of Health Annual Report, published in PBHAR, 1919, 233. Typically, there were several female physicians who worked with the nurses in the field. They deserve a separate analysis.

16. Ibid.


18. Typescript, "Proceedings of Meeting of the Provincial Board of Health, March 5, 1917," AO, RG 8, I-1–A-1, Box 64.

19. For example, Miss Power spoke only eight times; the transcript is thirty-seven 8" x 11" pages long.

20. Ibid., 5, 36, 37.

21. Ibid., 36.

22. Ibid., 37.


25. Miss Dyke herself said that the public health nurse was "called to assist the health officer" and that he "granted initiative to his public health nurse." She also cautioned that the nurse should never express "an opinion of the capacity of the physician chosen by the patient." "The Public Health Nurse," Paper read before the Annual Conference of Illinois Health Officers and Public Health Nurses, 14 October 1928. (Published by the State Department of Health. Found in the Archives of the Canadian Nurses' Association.) Miss Dyke was fired in 1932 after she publicly defended a nurse on staff against a physician.

26. Mary Sewall Gardner, *Public Health Nursing* (New York: MacMillan Co., 1916), 38–39. Gardner was one of the early leaders of American public health nursing; in 1905 she became the Superintendent (later Director) of the Providence District Nursing Association in Rhode Island, heading it until her retirement in 1931. Her greatest contribution

27. Gardner, 4. Emory advised her readers that “mutual trust and respect” must exist between the medical doctor and the public health nurse. When the physician feared “encroachment” of the nurse, Emory admonished that “possibly again the public health nurse may have over-reached herself in her zeal and forgotten the responsibility of the physician for his patient.” The public health nurse was warned to “never diagnose” and “never prescribe” (even for the common cold or a headache), and “never give treatment apart from medical supervision.” Health teaching was “conceived as supplementary to medical care” [emphasis mine] and one of the public health nurse’s functions was “strengthening the bond between the physician and his patient.” In *Public Health Nursing in Canada: Principles and Practices* (Toronto: Macmillan Co., 1945), 119-124.


32. Ibid.

33. Ibid.

34. Ibid., 13 August 1986.

35. See, for example, all the published work of Dr. Alan Brown, Chief of Pediatrics at the Toronto Hospital for Sick Children for thirty years, as well as the writings of Dr. Helen MacMurchy.

36. Squires to Power, 14 August 1923, AO, RG 62, Flb, Box 475. Evidence that rural (and urban) physicians were unfamiliar with feeding infants and children is provided by Dr. Alan Brown, “Problems of the Rural Mother in the Feeding of Her Children,” *CV14* (July 1918): 1160. Mothers may also have asked for formula feeding instructions, influenced by widespread commercial baby-food advertising.

37. Carr-Harris to Knox, 10 December 1920, AO, RG 62, Flb, Box 478. See also Carr-Harris to Knox, 22 November 1920.

38. Carr-Harris to Knox, 22 November 1920.

39. The tone of all letters from Kenora in the fall and winter of 1920-1921 indicated that the nurses wanted to keep their superiors informed of the situation, lest they make a mistake and cause problems for their employer.
40. Gipson to Power, 17 March 1921, AO, RG 62, Flb, Box 474. (All Gipson's subsequent correspondence is to be found in this source.)
41. Squires to Knox, 5 July 1924; Squires to Power, 23 January 1924. (And reply.)
42. Squires to Power, 11 October 1922.
43. Squires to Power, 16 May 1924.
44. Squires to Power, 9 January 1924; J. O. Herity to M. R. Heeley, 5 March 1922, letter in the possession of MHW.
45. Squires to Knox, 2 August 1924.
46. Carr-Harrist to Phair, 26 September 1926, AO, RG 62, Flb, Box 479.
47. See, for example, Gipson to Knox, 17 March 1921. All of the nurses were single. Full-time paid work and marriage were seen as incompatible in this period.
48. Squires to Knox, 22 July 1922. (Marked "personal.")
49. Corbman to Power, 22 December 1922; Corbman to Power, 31 August 1923. Both in AO, RG 62, Flb, Box 479.
50. Gipson to Knox, 1 March 1922.
51. Bagshaw to Knox, 4 November 1921 and Knox to Bagshaw, same date; Knox to Bagshaw, 20 December 1921; letters from Thessalon were written 9 November 1920 and 20 December 1920, AO, RG 62, Flb, Box 478. The blatant anti-Semitism was unfortunately all too common in the early twentieth century.
54. Squires to Knox, 7 April 1922, AO, RG 62, Flb, Box 475.