Caring and Curing
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Motherhood, that is, childbearing and child rearing, constitutes one of the main components of modern homemaking. Indeed, it was precisely that responsibility, assigned exclusively to women, that justified the existence of a domestic environment separate from the world of business, and the assignment of women to that environment and the activities pertaining to it. This new separation of social roles, brought about by industrialization and based on the concept of the breadwinner–homemaker couple, was accompanied by the emergence of a glorification of motherly love and the mother–child relationship and the designation of motherhood as the primary and exclusive vocation of women.¹

Ironically, while women were said to be endowed with an innate maternal instinct that made them alone able to devote themselves entirely to the care of young children, the field of obstetrics and infant care began to be invaded by a host of new “experts,” particularly social reformers and physicians. At the end of the nineteenth century, by which time midwives had been practically eliminated, at least in urban areas,² women’s knowledge of child rearing began to be looked down upon, and women were urged to seek and follow the advice of a doctor, both concerning their pregnancy and about child care. Scientific discoveries about hygiene and the spread of disease lent credence to these recommendations, which were presented as the most effective way to combat infant mortality.³ Those who neglected to consult the doctor and who preferred bottle-feeding were soon to be strongly upbraided and deemed responsible should their children die.⁴

However, it took several decades before the medical profession had complete control over child care and obstetrics in all social classes. It was relatively easy to convince well-to-do women to submit to medical
checkups throughout their pregnancies and to follow the recommendations of their physician with regard to hygiene and the feeding of newborns. Indeed, middle-class feminists and public-health physicians collaborated closely in promoting the cause of public health and reducing infant mortality. It was much more difficult to induce working-class women to consult a physician, mainly because of the cost involved. Shortly before World War I, various organizations were created with a view to providing maternal care to those who could not afford such a luxury, and they seemed to play a crucial role in the medicalization of delivery and infant care.

Indeed, according to the reports of thirty Montreal working-class women who were married between 1919 and 1934, they rarely consulted the doctor more than once or twice during their pregnancies. However, the interviews showed that almost all of them had availed themselves of the free medical services offered by one of the organizations that will be studied in this paper. These are the visiting nurse program of the Metropolitan Life Insurance Company, used by more than one third of the women in the sample (twelve out of thirty), the Gouttes de lait clinics, which almost all of them visited (twenty-seven out of thirty), and the Assistance maternelle program, which helped a few respondents who were particularly poor (three out of thirty). The reports of these women show that it is by these means that medicine succeeded, not without some difficulty, in educating poorer women about its new standards in this area. To illustrate this process, we shall briefly review the history of these three organizations, defining their objectives, the services offered and the clientele they targeted, and then consider the assessment of them, by the women in my sample, as well as their opinions on medicine and the medical profession.

The Visiting Nurses of Metropolitan Life

Thanks to premiums as low as five cents per week and to its system of weekly collection by agents, the Metropolitan Life Insurance Company succeeded from the beginning of the century in attracting a working-class clientele, both in the United States, where it was founded, and in Canada. To combat the high mortality rate of its members, and at the instigation of a New York philanthropist, Dr. Lee Frankel, the company decided in 1909 to create a Welfare Division that would disseminate information on precautions to be taken against the infectious and contagious diseases that were ravaging its clientele.
In that same year, this time at the suggestion of Lilian D. Wald, a friend of Frankel’s who was the nurse responsible for the Henry Street Settlement in New York, the company agreed to carry out a three-month, experimental program of visiting nurses for its sick policyholders in a poor district of Manhattan. The nurses would visit the policyholders at the suggestion of the agents who collected the policyholders’ premiums at their homes every week, and who were thus able to identify those who needed particular care. The experiment was so successful that the company had no choice but to gradually extend it to its entire clientele. By the end of 1909, thirteen American cities were benefiting from this service; five years later, it was operating in 1,804 American and Canadian cities. In the mid-1930s, when it reached its fullest expansion, the service was available in over 7,000 municipalities throughout North America. When the company finally discontinued the service in 1953, over twenty million policyholders had received over one hundred million visits from these nurses.\(^8\)

Despite the high cost of the visiting nurse program, it proved very worthwhile, as in 1918 the company found that the mortality rate of its policyholders had dropped by 18% in seven years, even taking into account the deaths due to the influenza epidemic following World War I. During those same seven years, the company estimated that 18% of the nurses’ visits had been to pregnant women before and after delivery, which resulted in a drop in infant mortality of 46.5% among the company’s policyholders compared to a drop of only 10.8% in the general population.\(^9\) In the 1920s and 1930s, over 30% of visits were devoted to pregnant and post-partum women.\(^10\)

In Canada, the company set up its first visiting nurse programs in Montreal and Halifax in 1910, that is, one year after the service was introduced in the United States. The following year it was expanded to Quebec City, Toronto and Winnipeg. Wherever it could, be it in Canada or the U.S., the company provided this service through local visiting nurse associations, paying a fee to the association for each visit made on the company’s behalf. In areas where no such service existed, the company hired nurses directly. Thus, in Montreal, the Victorian Order of Nurses (VON) was approached to serve the company’s English-speaking clientele, while the Sœurs de l’Espérance looked after some of the French-speaking clientele until 1923, when they terminated their association with the company.\(^11\) The amount of paperwork involved, and the large proportion of maternity cases that they were expected to handle, were given as reasons for discontinuing the association;\(^12\) for its part, Metropolitan Life was frustrated that the nuns were unable to
cover the entire city due to lack of personnel, which forced the company to resort to arrangements that were often awkward, such as sending nurses from the VON, who did not speak much French, to visit Francophone patients.\textsuperscript{13} To solve its difficulty in recruiting French-speaking personnel once and for all, the company finally decided to get involved in the training of public-health nurses by making a financial contribution towards the founding, in 1926, of the School of Applied Public Health, affiliated with the Faculty of Medicine of the Université de Montréal, which became its main source of nurses.\textsuperscript{14}

When the service was set up in 1909, it was intended exclusively for policyholders who were suffering from acute illnesses. The growing interest of government authorities in the phenomenon of infant mortality, both in the U.S. and Canada, convinced the company to liberalize its policy. In 1914 it decided to allow eight postnatal visits to any mother who requested them, provided that she had held an insurance policy for one year. Later, beginning in January 1916, pregnant women were also entitled to two prenatal visits, and then to four beginning in 1920, provided that the pregnancy was reported before the sixth month. Finally, in 1922, the number of prenatal visits was increased once again; expectant mothers could benefit from a maximum of eleven prenatal visits—one per month from the first to the seventh month of pregnancy and two during the eighth and ninth months, plus eight postnatal visits during which the nurse also cared for the newborn.\textsuperscript{15} In order to receive prenatal visits, the patient had to have consulted her physician first; for postnatal visits, Metropolitan Life’s visiting nurses had standing orders that authorized them to take care of new mothers without any specific recommendation from an attending physician.\textsuperscript{16}

During prenatal visits the nurses’ duties consisted of informing the patient about hygiene during pregnancy and the importance of a sound diet and plenty of rest. They taught the rudiments of child care, insisted on breast-feeding and tried to encourage the patient to visit her physician regularly and to have urine samples analyzed to avoid problems of albuminuria and eclampsia. Towards the end of the pregnancy, the nurses also had to show the patient what articles to prepare for the birth (which took place in the home) to ensure that conditions were as hygienic as possible. The nurses did not attend the birth, as the company felt that this would have taken up too much of their time, but they made at least eight postnatal visits. At each visit they would give a bath to the mother and to the baby, check the condition of the breasts and the perineal area, clean and put a dressing on the baby’s umbilical
cord and provide any other care prescribed by the physician, in addition to continuing to educate the patient.\textsuperscript{17}

The creation of a visiting nurse service by a private company such as Metropolitan Life was a specific response to an economic necessity. Its program of maternal and child care was strictly limited to its working-class policyholders\textsuperscript{18} and its main objective was to reduce the costs associated with fetal and neonatal mortality. The company targeted this segment of its clientele because it believed, as did all the social reformers of the time, that the poorest women were also those who had the greatest need for care and counselling during pregnancy. The service was designed to educate them about hygiene and nutrition but also to induce them to consult a physician more regularly.

\textbf{Les Gouttes de lait}

Les Gouttes de lait\textsuperscript{19} was undoubtedly the best known of the three organizations studied, although their origins are less well known. The first clinic was created in 1901 by a small group of Montreal doctors at the instigation of a reporter for the \textit{La Patrie} daily newspaper, Madeleine (Mrs. Huguenin), and of Mrs. Justine Lacoste-Beaubien.\textsuperscript{20} The newspaper undertook to sponsor the project. Their initial objective was to combat infant mortality by distributing high-quality milk to mothers in the poor neighbourhoods of Montreal who could not (or did not wish to) breast-feed. The first clinic was located on Ontario Street, at the corner of Plessis; it was obliged to close down after just a few months due to lack of funds. The idea was revived two years later, this time at the instigation of Anglophone and Francophone physicians who founded the Pure Milk League. Financed in part by the City of Montreal, the League was successful in opening four distribution offices that operated only during the summer months, when diarrhea was most prevalent among babies.\textsuperscript{21} From 1910 onwards there were more successful attempts to organize Les Gouttes de lait on a permanent basis. In that year, three independent clinics were set up, one by Mgr. Le Pailleur in the parish of Saint-Enfant-Jésus, a second by the Fédération nationale Saint-Jean Baptiste, affiliated with the Hôpital Sainte-Justine, which had been founded just three years earlier,\textsuperscript{22} while the English-speaking community set up a third. In 1911, ten new clinics were added, endowed with a municipal grant of five hundred dollars each. As early as 1913, the centres multiplied, generally one per parish. In that same year, the first convention was held of representatives of all the French-speaking
Gouttes de lait clinics, under the chairmanship of Dr. S. Lachapelle, for the purpose of reviewing the problems facing the organization and means of expanding it. The following year the centres reorganized under the administration of the Bureau central des Gouttes de lait de Montréal, consisting of the director of the public health office and members elected by local committees. This central office was supposed to organize new local committees, oversee the operation of the Les Gouttes de lait and distribute funding, which was now centralized. The local committees, consisting of the parish priest, attending physicians and volunteer women, were responsible for providing consulting services, distributing the milk and providing assistance to mothers. In 1927 the Bureau central des Gouttes de lait was replaced by the Fédération d'hygiène infantile.

In 1915 there were twenty-eight Gouttes de lait clinics in Montreal, including five English-speaking Milk Depots, which still concentrated essentially on the distribution of high-quality milk. In 1919, the health department of the City of Montreal set up fourteen baby clinics (also known as Gouttes de lait) staffed with graduate nurses. Ten years later, there were twenty-seven of them. From the early 1920s onwards, whether public or private, Les Gouttes de lait seemed to focus more on medical checkups of infants than on the distribution of milk, which was by then widely pasteurized (this was mandatory by 1926). Thanks to parish priests, who promoted Les Gouttes de lait from the pulpit, and to columns in newspapers like La Patrie, all mothers in working-class neighbourhoods, not just the poorest ones, were invited to bring in their babies for regular checkups during their first few years of life. Often the clinics were located in premises loaned by the parish, which also recruited volunteer women to look after administrative duties, while the city's public health department paid the physicians and nurses. Beginning in the 1930s, the municipal clinics also offered prenatal consultations during which women learned how to care for and feed their children and were given advice on general matters of hygiene. In 1935 Montreal had forty-two baby clinics operated by the city's health department, seventeen Gouttes de lait clinics operated by the Fédération d'hygiène infantile and thirteen clinics sponsored by the Child Welfare Association, for a total of seventy-two. They had evolved from a clean milk distribution service, aimed at the needy, into a consulting service open to all mothers, except the most well-off, who could afford to consult their family physician. These consultations focussed on educating mothers and detecting illness in children. No treatment, except for vaccinations, was administered or prescribed at these clinics.
Assistance maternelle

The poorest mothers in Montreal could avail themselves of the service of an association founded in 1912 by Caroline Leclerc Hamilton (also a founding member of the Fédération nationale Saint-Jean-Baptiste) called Assistance maternelle. This organization, which is still in existence, adopted the goal of combating infant and maternal mortality by helping destitute women during and after their pregnancies. Despite the opposition of certain priests who, it seemed, saw no necessity for such work, Mrs. Hamilton succeeded in setting up parish-based committees, which grew in number from eighteen in 1917 to thirty-eight in 1936.25

Each parish committee organized a workroom, set up sewing circles and took care of cases that were referred to it, often by other charitable organizations such as the Société Saint-Vincent-de-Paul. The volunteer women on these committees visited the homes themselves (usually to confirm the dire poverty of the individuals in question), distributed food, furniture, and clothing, including the baby's layette, and taught the mothers principles of hygiene and child care. They also provided free medical care before, during, and after delivery.

To accomplish the latter activity, the organization equipped itself from the very beginning with a dispensary where physicians provided free consultations to these mothers, two afternoons per week. The dispensary moved several times into ever larger premises, and eventually operated five days per week. Indeed, the medical care of these mothers took on increasing importance as the years went by, as even the home visits were taken over by nurses hired by Assistance maternelle, replacing the volunteers who had no medical training. From the 1920s onward, women who came in for a checkup were invited to enjoy a snack while a nurse lectured them on prenatal hygiene, the feeding of newborn babies, and child care.26

From 1922 to 1926, Assistance maternelle had a small ten-bed hospital for the care of widowed or abandoned mothers or the treatment of serious cases requiring care that could not be provided at home. Over those four years, the hospital admitted 601 patients.27 After that, the organization simply paid the cost of delivery when necessary, be it at the mother's home or in a city hospital. In 1924, the organization provided assistance to 824 mothers and distributed 374 layettes; in 1932, one of the most difficult years of the Depression, it helped 4,194 mothers and supplied over 2,000 layettes.28
By various means, and by targeting specific clientele, these three organizations worked principally to prevent infant mortality in order to reduce the social and private costs associated with it. Through brochures, lectures, home visits or checkups in clinics, all three sought to educate mothers about hygiene and nutrition, as the ignorance and negligence of working-class women were then considered the primary causes of the high mortality rates among small children. The restrictions that were attached to the free services provided by Metropolitan Life and Les Gouttes de lait (e.g., the requirement that women first consult a physician in order to be entitled to prenatal visits by the nurses of Metropolitan Life, and the lack of treatment for sick children at Les Gouttes de lait) also indicate that one of the objectives of these organizations was to induce women to consult a physician during their pregnancies and for childhood illnesses. Thus humanitarian motives, not devoid of financial considerations, were accompanied by a desire to extend the reach of the medical profession.

Mothers, Doctors, and Nurses

Were the educational efforts of these organizations effective? Did the women welcome the advice that was given to them? How did they feel about the health professionals, doctors, and nurses, who tried to get them to adopt new behaviours during their pregnancies and in the way they cared for their children? The testimony drawn from interviews sheds some light on these questions.

It should first be pointed out that, contrary to the wishes of physicians, most of the women in the sample did not consult a medical practitioner until the sixth or seventh month of pregnancy. If everything went smoothly, they did not see him again until the delivery. A few of the women interviewed had never met the doctor before then; on the other hand, a few others had several checkups during their pregnancy. These were either women who were better off financially (in just a few cases) or the most destitute, i.e., those that were cared for by Assistance maternelle (in three cases). The testimony of one respondent indicates that the physicians affiliated with that organization insisted that patients submit to regular medical care in exchange for the material support provided:

They gave us a large flannelette blanket, two sheets and pillowcases, and clothing for the baby: three nighties, three undershirts, a dozen diapers, little socks and little woollen sweaters. They made up a package for us.
Then, they kept an eye on us. You know, you had to go once a week. In my case, they gave me a bassinet, and bottles. We went to Assistance maternelle in the afternoon. There we had a snack, the doctor was there, the nurses gave us advice just like when people go to prenatal courses today. Since I was obliged to drink a lot of milk, they sent me to the Poupart company where I was given two quarts of milk free of charge. I didn’t pay for them; they did.29

Assistance maternelle also paid for the hospital deliveries of two of the three women in the sample who used its services. The testimony of one of them implies that these women served as case studies for the young doctors who came to examine the patients before and after delivery: “There were lots of doctors around me, around the bed, and they examined us. The doctor was there and explained why the delivery had been difficult.”30 This respondent did not appreciate being treated in such a fashion. She also complained that she never received the layette that had been promised her, on the pretext that this was her first child and her husband was working. (Because of the Depression his wages were only $10 per week.) On the other hand, none of the respondents complained of the medical care to which they were obliged to submit. However, their comments suggest that they attached greater importance to the material assistance provided in the form of linens, clothing and various supplies for the baby and the snacks provided during their visits, than they did to the advice offered during the lectures that they were obliged to attend. Indeed, their memories of those lectures were rather vague, which would indicate that the information provided did not leave much of an impact.

Twelve of the thirty women interviewed received visits from Metropolitan Life’s visiting nurses during one or more of their pregnancies. As they did not see a doctor until around the sixth month, they could only receive a portion of the prenatal visits allowed by the company’s regulations. According to their reports, the main subject of these visits was the preparation for the delivery, and the nurses seemed to focus mainly on the cleanliness and asepsis of the linens and accessories:

From the seventh to the ninth month, she [the nurse] came to show us how to make quilts for the delivery. She made us take newspapers, sterilized in the oven, and we bought cheesecloth.31 She had us alternate layers of newspaper and cheesecloth. We quilted them together with large stitches. She had us make small ones and large ones.32
In those days when we had insurance from Metropolitan Life, the nurses would come. When we were pregnant, they would come visit us, and explain what to do, and had us make newspaper quilts. We took several layers of newspaper, along with a piece of cotton, pillowcases, or old sheets, and we sterilized them with an iron. That made it very clean, and then we sewed it all together around the edge with large stitches. To make sanitary napkins we took a piece of sterilized cotton and put cotton batting. When we gave birth at home everything was ready. When the doctors came into the house they were not revolted; the towels and absolutely everything were clean. She [the nurse] came and showed us how to prepare our breasts for having the baby, and then she had us make our quilts, so that everything was ready.\footnote{33}

We prepared a tray with everything the baby would need. We put a bar of soap, and stuck safety pins into it. The diapers in those days were not like they are today. It was easier to get the safety pins through them if you poked them into soap first. We had a whole lot of jars with clean lids to hold boiled water. And for the umbilical cord, for the navel, there were cloths of real linen. We cut out squares with holes in the middle to thread the umbilical cord through. We wrapped it all up in a clean cloth and then put it in a cool oven to sterilize it. Then that was wrapped up in another clean cloth. All this was on a tray. When the nurse came [in the days following the birth] she used the tray with a pot full of water that had been boiled to give us our sponge bath.\footnote{34}

According to another respondent, the tray also had to hold oil, powder, cotton batting, etc. These preparations were certainly more complicated than those performed by other women who did not benefit from this service; as one of the respondents, already quoted above, pointed out, “Let me tell you, we worked hard in those days when we had a baby, and we were not rich either!”\footnote{35}

The preparation of all these materials did indeed take a lot of time, but only one of the respondents disliked the service specifically for that reason: “It was a whole lot of bother, get out this, get out that,” she said.\footnote{36} The others quite appreciated the services of Metropolitan Life’s visiting nurses, not for the advice they gave on hygiene during pregnancy or on nutrition, which they never mentioned, but because these preparations, although time-consuming, gave them a sense of security and saved a lot of work at the time of the delivery:

Even if I had asked my mother [how to prepare for the delivery], she did not even know because, in her day, they used whatever they had on hand. They did not take as many precautions as we did. We took precautions. I made quilts; I cut up old sheets, laid a thick layer of newspaper in
between, and sewed it all around; it saved a lot of laundry. We even made our own sanitary napkins. I made dozens and dozens of them, and then we threw them away. It saved a lot of laundry.\textsuperscript{37}

[The quilts and the home-made sanitary napkins,] those were meant to be thrown out. When we gave birth, it made a mess, right? So, this saved you a lot of work. Because we got a lot of sheets and other things dirty. They [the nurses] changed our bed every day. Otherwise, if we had had quilts [store-bought ones], you didn’t throw those ones away, you washed them.\textsuperscript{38}

They also appreciated the daily visits by the nurse during the eight or nine days they had to stay in bed after the birth: "When we had a baby, the nurse from Metropolitan Life came every day. She bathed us, bathed the baby and showed us how to bathe the baby. My dear, it was wonderful!"\textsuperscript{39} The interviews showed that it was not always easy for these women to get help after the birth. Death, distance or responsibility for a still growing family were reasons that only a minority of the respondents benefited from the assistance of their mother or mother-in-law after the birth. For those women in particular, there is no doubt that the reassuring presence of the nurse was a valuable source of support. It should be pointed out that the nurse took care of the mother and baby only, which was not true of relatives (mother, mother-in-law, sister, cousin, etc.) who, when they were able to help out, generally devoted some of their visits to household chores that had been put on hold.

Only a few of the respondents took advantage of the prenatal consultations offered by Les Gouttes de lait. According to their reports, the purpose of these consultations was to teach them how to care for the new baby and to show them how to prepare the material they would need for the birth; generally speaking, the latter instructions resembled those given by the nurses from Metropolitan Life. However, the vast majority of the respondents did visit Les Gouttes de lait with one or more of their children, who were examined, weighed and vaccinated, and the young mother received advice on nutrition and infant care.

Although almost all the respondents took advantage of this service, not everyone was pleased with it. For various reasons, some mothers did indeed appreciate it, particularly in the case of a first child: "I found that it helped young people who didn’t know anything, like myself," declared one respondent.\textsuperscript{40} "It was very useful," stated another, "they gave the children their shots, which saved us a visit to the doctor."\textsuperscript{41} "It was our only opportunity to have the children weighed," added another.\textsuperscript{42} On the other hand, many respondents emphasized
that the clinics involved significant inconvenience. One respondent explained, “I didn’t care for it much because when we got there, the baby was subjected to a change in temperature: they took off all his clothes. Some of the children there had colds, others had whooping cough.” Apart from the risks of contagion, many respondents also pointed out that, when the second or third child came along, it became more difficult to get to the clinic: “But after that, with three (children), I stopped going to Les Gouttes de lait. I would have had to take all three.” Since the baby was given a rather cursory medical examination and the clinics restricted their medical activities to screening, going to Les Gouttes de lait with several children was considered a useless extra bother. Moreover, after one or two pregnancies, the mothers had gained some expertise in the diagnosis and treatment of common childhood diseases:

When the children were sick, we were the ones who took care of them. We knew what it was, all the children went through it. For measles, we kept them in the dark; we learned this on our own, by word of mouth. I had older sisters; watching them, I learned these things automatically, I guess.

Although it seems to be an exception, the report of one respondent also shows that conflicts could arise between the mothers and the health professionals on how to care for the baby:

As for me, I never enjoyed going to Les Gouttes de lait. At Les Gouttes de lait, they told us “Hey, don’t give that to your baby, he will die; don’t give that to your baby, it will make him sick. Give him this, don’t give him that.” They used to make the children sick with all that. I went with my children. The nurse didn’t want me to give the baby solid food before the age of nine months. The baby was crying day and night. No matter how much milk I gave him, I could not fill him up with that. So, I started giving him solid food. When she found out, she told me not to go back to Les Gouttes de lait because I was an unnatural mother who didn’t want to raise her children properly.

There was another respondent who preferred to go to the English-speaking clinic because she found the staff there did not lecture as much.

Although the advice given by Les Gouttes de lait was much appreciated by young mothers who were inexperienced or lacking help from other sources, it would seem that it became less important after the second or third child was born, as the women then felt that they had
acquired sufficient expertise to care for the baby on their own. Since serious health problems were not treated at Les Gouttes de lait, many respondents saw no need to make regular visits, which took up a lot of their valuable time. Despite the wishes of the clinics' promoters, who insisted on the necessity of regular medical visits for all children, few women in our sample took all their children there on a regular basis.

The competence of the health professionals and the practicality of their knowledge were also questioned by the respondents. Most of the women admitted that they would not have relied only on a midwife to have their babies, as many of their mothers had done, because they felt it would be too risky. In this respect, it would seem that the medical establishment's claims about the incompetence of midwives, compared to the "modern" knowledge and techniques that only doctors could provide, carried the day. This did not prevent the respondents from criticizing, sometimes harshly, the practices of certain obstetricians. For example, during her first delivery, one respondent, to whom the doctor had given ether, reported she was too drowsy to push, and the doctor had to use forceps, nearly pulling off the baby's head: "It was real butchery," she said. "If the doctor had been competent, he might have saved him." Another, whose perineum was torn during her first delivery, recalled indignantly that the doctor had told her that there was no point in sewing it back: "We'll do that for you when you've finished having children," he told her. Many women also pointed out that despite the doctor's fee, which was between $10 and $25 (more than a week's salary for some), often he did not arrive until the child was already born: "When the doctor arrived, only the lower portion of the child's body remained to come out." Furthermore, the doctors did not wash the baby, leaving that "duty" to a woman, whether private nurse, midwife (usually a neighbour, so called due to her experience with childbirth) or relative who had come to help out the mother. Given these circumstances, it is not surprising that some of them questioned the usefulness of having the doctor come, although not until after the fact.

The women were particularly skeptical about the performance of modern medicine with respect to the fight against infant mortality, which was still high at the time. In speaking of her first child, who died of complications of jaundice, one respondent said, "That child would not have died if he had been born today." Another explained, "In those days, women had fifteen or sixteen children and lost five, six, sometimes more. They died in babyhood. In those days, the doctors
didn’t know anything.” Many respondents also asserted that they had cured their children using traditional medicines, after applying the doctor’s recommendations to no avail. In at least two cases, premature infants were saved thanks, not to a doctor’s care, but to that of a mother-in-law or a neighbourhood midwife: “The old women said, ‘That child will not live.’ It was my mother-in-law who saved him. He had no fingernails, and was not pleasant to look at. He was lying in his bassinet and my mother-in-law had surrounded him with hot water bottles,” said one respondent. According to another respondent, Paregoric, a medicine that was popular at the time, was even dangerous for children: “It made them sleep so soundly that we were afraid they were dead.”

Whether well-founded or not, these criticisms show that medical science and its practitioners had not yet won everybody over, and that women were quite critical about the invasion of these so-called “experts,” especially into the realm of child rearing. Despite the position of the medical establishment, which held women responsible for infant mortality, the women generally considered that this was an inevitable phenomenon, given the state of medical science at the time—thereby throwing the ball back into the other court.

The same reticence is revealed in the small proportion of women who breast-fed their babies. Despite numerous preachings in favour of nursing, the only effective way to combat infant mortality according to the “experts,” half of the women interviewed did not breast-feed, and of those who did, many stopped after the first month. The report of one respondent who did nurse seems to show that, contrary to the claims of the medical profession, breast-feeding was not necessarily a panacea against infant diarrhea. “We had a lot of problems with stomach upsets. He was born with diarrhea; I was never able to stop it. I lost him after seven weeks.”

A lack of breast milk, due to the poor health of these women or to malnutrition, as well as the numerous inconveniences associated with the practice, explain why women did not nurse more often or for longer periods. The amount of attention the mother had to give to the baby, the impossibility of doing anything else at the same time, and the isolation in which nursing had to take place so as not to transgress the rules of modesty, all contributed towards many mothers giving it up, especially when there were other children demanding their care and attention. Most of the women did know, however, that nursing could help postpone the next pregnancy, and those who nursed for a long time generally did so for that reason.
Conclusion

The organizations studied in this article, particularly the visiting nurses of Metropolitan Life and Les Gouttes de lait, wanted above all to educate women about hygiene and nutrition and convince them of the necessity of regular medical care for themselves and their children. The reports of the women in our sample show that, in fact, the women attached little importance to the educational efforts of these organizations, although they did succeed in inducing the women to adopt certain practices and accept certain services from health professionals, particularly from nurses.

Of the three organizations studied, the visiting nurses of Metropolitan Life seemed to be the most appreciated by the women who benefitted from their services. The majority of women who held an insurance policy from that company called upon the visiting nurses regularly for all their pregnancies, whereas, after the second or third child, most felt that the advice received at Les Gouttes de lait was not worth the bother of going. Contrary to the consultations offered by Les Gouttes de lait, the visiting nurse service, which went to people's homes, was certainly better suited to the circumstances of mothers for whom getting around town was a problem. This explains, in part, its popularity. But more importantly, the advice and care provided truly met their needs. For one thing, the nurses' instructions resulted in the delivery taking place in a hygienic environment that reduced the risk of infection and puerperal fever (risks of which the women were well aware and feared above all else), besides reducing the amount of housework associated with a home birth. For another, the postnatal visits helped prevent discomfort or more serious complications that might otherwise develop, and enabled the women to rely on a professional while they recuperated.

Only three respondents used the services of Assistance maternelle—too few to enable us to draw any definitive conclusions. However, it may be noted that, here again, the services offered seemed to be evaluated according to whether they met the women's material needs. Finally, we must emphasize the women's extreme ambivalence towards doctors. For one thing, they did not seem to attach much importance to regular medical consultations throughout their pregnancies, the behaviour the medical profession wanted them to adopt. Despite all the awareness campaigns and pressures that were applied, including making them feel guilty, these women did not change their practice of waiting until the latter part of their pregnancy. Admittedly, their
finances did not allow them to indulge in frequent medical visits, let alone pay for the blood and urine analyses that were recommended; but it is striking that this did not seem to worry them unduly. The frequency of their pregnancies, which made them a familiar phenomenon, undoubtedly had something to do with it. As one of the respondents said, "having children was part of life." On the other hand, it does seem that they were unwilling to take the risk of doing without a physician during the delivery, although, in practice, the doctor often played only a minor role. It should also be noted that doctors and medicine in general were the subject of several rather angry comments, while this was not true of the nurses, and that the women did not have much faith in the doctors with respect to pediatric care.

In short, although they did not absolutely refuse any type of medical care, nor systematically reject the advice and instructions they were given, the women in our sample showed a certain skepticism towards what the health professionals told them. The professionals succeeded in influencing certain behaviors, but only inasmuch as the women themselves felt a need for these changes or believed that they would be beneficial. Their acceptance of visits from Metropolitan Life's nurses and their decision to visit Les Gouttes de lait, especially for their first children, clearly show this. The efforts of doctors and nurses to oversee women's pregnancies and care of children were not wasted, however: witness the growing hospitalization of births during and, especially, after World War II and the generalization of pediatric care that occurred at about the same time.

Endnotes

1. Views of motherhood have already been the subject of numerous writings and analyses. For a view of the Quebec context, see Andrée Lévesque, La norme et les déviantes. Des femmes au Québec dans l'entre-deux-guerres (Montreal: Éditions du Remue-ménage, 1989).


3. Infant mortality remained particularly high in Quebec until World War II. In the working-class districts of Montreal at the turn of the century, nearly one infant out of three died during its first year of life. In 1922, the infant mortality rate was still 218 per thousand in those same districts. It did not start to really decrease until the end of the 1920s, when the pasteurization of milk was made mandatory, dropping from 139.7 per thousand to 59.3 per thousand between 1928 and 1940. Terry Copp, The Anatomy of Poverty. The Conditions of the Working Class in Montreal, 1897–1929 (Toronto: McClelland and Stewart, 1974), 93; "The Health of the People: Montreal in the Depression Years," in A. E. Shepard and
Andrée Lévesque, eds., Norman Bethune, His Time and His Legacy (Ottawa: Canadian Public Health Association, 1982), 129.


5. For example, the Fédération nationale Saint-Jean-Baptiste, the voice of Montreal middle-class feminists, was closely involved in the founding of Hôpital Sainte-Justine, the Milk Depot network and the visiting nurse program that will be discussed later.

6. These interviews were carried out as part of the research for my doctoral thesis, published under the title Ménagères au temps de la Crise (Montreal: Remue-ménage, 1991).

7. Dr. Frankel's first target was tuberculosis, which was killing twenty percent of the company's members each year. 3,500,000 copies of a brochure, written in twelve languages and describing methods for preventing the illness, were distributed by the company's agents. James Marquis, The Metropolitan Life, A Study in Business Growth (New York: Viking Press, 1947), 186–188. For a history of the company's visiting nurse program in the United States, see Diane Hamilton, The Metropolitan Life Insurance Company Visiting Nursing Service (1909–1953) (Doctoral thesis in Nursing, University of Virginia, 1987). For Quebec, see Denyse Baillargeon, "Les infirmières de La Métropolitaine au service des assurées enseignantes" (in progress).


9. Marquis, The Metropolitan Life, 207. These seemingly spectacular results should be taken with a grain of salt, as they do not take into account the fact that the poorest segments of the population, which were at the greatest risk, were most likely not insured by the company.

10. See Baillargeon, "Les infirmières de La Métropolitaine."


14. The school was financed by the provincial government, the City of Montreal, the Antituberculosis League and Metropolitan Life, which contributed nearly $78,000 between 1926 and 1933. (MLIC, MLIC Nursing Service in Canada, 2–5, 7 and Dominique Guicher, "La formation des Hygiénistes à l'Université de Montréal, 1919–1975: De la santé publique à la médecine préventive," Recherches Sociographiques XX, 1 (January-April 1979): 65–66.)


18. Only holders of so-called “industrial” (i.e., payable on a weekly basis), monthly (premiums paid monthly) or group (designed for industrial workers) insurance policies were entitled to visits from the company’s visiting nurses. Holders of “regular” policies (whose premiums were paid annually) did not have access to the program.

19. The French term “Gouttes de lait” will be used throughout to denote institutions known in English-speaking Canada as Milk Depots. As Milk Depots changed their name to Well Baby Clinics when their focus shifted away from supplying pure milk to a much broader range of health services for infants, we have decided to retain the French name, Gouttes de lait, as it did not experience a similar name change with a shift in function.


26. Ibid., 23–24.

27. Ibid.


29. Quote from interview no. 25.

30. Interview no. 13. According to Hélène Laforce, towards the end of the nineteenth century and into the early twentieth century, doctors in need of “guinea pigs” demanded access to the patients of maternity wards for single mothers in order to acquire obstetrical expertise. Around 1940, they officially claimed the clientele of Assistance maternelle. The experience of this respondent seems to indicate that the use of these women for teaching purposes was tolerated as early as the beginning of the 1930s (Laforce, *Histoire de la sage-femme*, 114–115).
31. This respondent was somewhat better off than the others; she is also the only one to mention the purchase of cheesecloth for making quilts. This detail suggests that the nurses adapted their instructions to suit the income level of the women they visited.

32. Interview no. 15.
33. Interview no. 2.
34. Interview no. 29.
35. Idem.
37. Interview no. 29.
38. Interview no. 2.
40. Interview no. 15.
41. Interview no. 5.
42. Interview no. 13.
43. Interview no. 20.
44. Interview no. 23.
45. Idem.
46. Interview no. 25.
47. Interview no. 16.
48. Interview no. 2.
49. Interview no. 7.
50. Interview no. 22.
51. Interview no. 2.
52. Interview no. 29.
53. Interview no. 11.
54. Interview no. 5.
55. Numerous articles published in the women’s pages of La Patrie urged mothers to breast-feed and established a direct correlation between breast-feeding and infant mortality. See, for example, “La majorité des maladies infantiles sont évitables,” La Patrie, 25 May 1931, 25; also Lévesque, La norme et les déviants and Dion, Les femmes et la santé, 97 ff. According to the latter author, a study of papers from conferences and other publications of the medical profession reveals that physicians attributed exaggerated benefits to breast-feeding.
56. Interview no. 2.
57. Interview no. 24.
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